MEDICARE MANAGED CARE: PAYMENT AND RELATED ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

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MEDICARE MANAGED CARE: PAYMENT AND RELATED ISSUES

THURSDAY, FEBRUARY 27, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:05 p.m., room 2123, Rayburn House Office Building, Hon. Michael Bilirakis, (chairman), presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Burr, Bilbray, Whitfield, Ganske, Norwood, Brown, Waxman, Towns, Stupak, Green, Strickland, DeGette, Furse, and Eshoo.

Staff present: Howard Cohen, majority counsel; Kay Holcombe, minority professional staff; and Bridgett Taylor, minority professional staff.

Mr. BILIRAKIS. The hearing will come to order. Good afternoon. Today's hearing begins our subcommittee's in-depth analysis of the administration's Medicare Managed Care proposals.

It will be the first of many hearings on the administration's budget initiatives in this area. Today's hearing will primarily examine Medicare's present HMO rate setting policies and the administration's proposals to modify these methods.

Currently Medicare payment rates to HMOs are calculated using a payment methodology called the adjusted average per capital cost, AAPCC. That's a mouthful and as we know the AAPCC is a complicated rate setting method which was certainly discussed to a large degree last year.

In its budget the administration claims that it is addressing the flaws in the current AAPCC rate methodology. At the same time, these proposals generate one-third of the President's Medicare savings from reductions in HMO payments even though HMO enrollees are only 12 percent of current Medicare beneficiaries.

It also involves a series of policy changes that are so complicated and convoluted that I have been told that only two people in the administration can adequately explain them and hopefully Bruce Fried, our first witness, is one of them.

So far I have identified at least eight policy adjustments that are applied simultaneously to the AAPCC in the administration's proposal. These factors are (1) delinking the AAPCC from Medicare fee-for-service payments—additionally, floors and ceilings on the AAPCC rates for certain counties, a hold harmless and minimum update factor, blended payment rates, a GME-IME DSH carve-out, a budget neutrality adjustment, a 5.3 percent reduction due to fa-

vorable selection, and an update factor tied to overall Medicare growth.

Although it's hard to believe, this AAPCC formula makes last year's Medicare block grant formula look elementary.

What we must not lose sight of is that for 5 million Medicare beneficiaries Medicare managed care plans have provided a superior health care delivery system without the need for Medigap insurance.

In addition, managed care plans have provided millions of elderly with prescription drug coverage, dental-vision benefits, and preventive benefits like routine physicals and immunizations.

This is a program which is growing at more than 30 percent per year because it is extremely attractive to our Medicare population.

It's clearly the wave of the future for Medicare and we must be extremely careful that we do not adopt legislative proposals that disrupts the system.

Thank you, and before we go to Mr. Fried, who is Panel One, I will recognize the members for an opening statement, but I would appreciate it if they would keep them as brief as possible. We don't want to get caught up, as we did the other day, when we spent almost the entire session for opening statements.

I am not going to time you, but hopefully we will keep them as brief as we can. Mr. Brown, ranking member.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

Today's hearing begins our subcommittee's in-depth analysis of the Administration's Medicare managed care proposals. It will be the first of many hearings on the administration's budget initiatives in this area. Today's hearing will primarily examine *Medicare's present HMO rate-setting policies, and the administration's proposals to modify these methods.*

Currently, *Medicare payment rates to HMOs are calculated using a payment methodology called the Adjusted Average Per Capita Cost (AAPCC). That's a "mouth full"—and as we know, the AAPCC is a complicated rate setting method.*

In its budget, the administration claims that it is addressing the flaws in the current AAPCC rate methodology. At the same time, these proposals *generate one-third of the President's Medicare savings from reductions in HMO payments, even though HMO enrollees are only 12 percent of current Medicare beneficiaries.* It also involves a series of policy changes that are so complicated and convoluted, that I have been told that only two people in the administration can adequately explain them. Hopefully, Bruce Fried, our first witness, is one of them.

So far, I have identified at least 8 policy adjustments that are applied simultaneously to the AAPCC in the administration's proposal. These factors are: (1) delinking the AAPCC from Medicare fee-for-service payments; (2) floors and ceilings on the AAPCC rates for certain counties; (3) a hold harmless and minimum update factor; (4) blended payment rates; (5) a GME, IME, DSH carve out; (6) a budget neutrality adjustment; (7) a 5.3% reduction due to favorable selection; and (8) an update factor tied to overall Medicare growth. Although it is hard to believe, this AAPCC formula makes last year's Medicaid block grant formula look elementary.

What we must not lose sight of, is that for five million Medicare beneficiaries, Medicare managed care plans have provided a superior health care delivery system without the need for Medigap insurance. In addition, managed care plans have provided millions of elderly with prescription drug coverage, dental, vision benefits, and preventive benefits, like routine physicals and immunizations. This is a program which is growing at more than 30% per year because it is extremely attractive to our Medicare population. It is clearly the wave of the future for Medicare, and we must be extremely careful that we do not adopt legislative proposals that disrupts the system. Thank you.

Mr. BROWN. Thank you, Mr. Chairman. Thank you for saying that so we can move onward today.

I would like to thank Bruce Fried, Director of the Office of Managed Care for joining us, and I especially thank the Chairman for holding this hearing. I think that he has discussed publicly and with many of us the importance of delving into managed care both in Medicare and Medicaid and in the private sector, in the work Dr. Ganske and others have done—all of that is particularly important.

While managed care has made significant inroads in the private health insurance market and among individuals covered by Medicaid, only 13 percent of all Medicare beneficiaries are enrolled in HMOs. However, attracted by prescription drug benefits, routine physicals, eyeglasses, dental care and reduced premiums, more and more seniors covered under Medicare are opting for managed care.

According to Forbes, some plans such as PacifiCare are becoming even more creative in attracting seniors by offering fitness center memberships and jazz evenings and other social events.

Based on these benefits and sophisticated marketing campaigns, enrollment in managed care among Medicare beneficiaries went up 25 percent in 1994 and then 36 percent in 1995.

With deeper market penetration among Medicare beneficiaries, I am pleased that President Clinton's budget proposal includes several important patient protection provisions which are similar to pieces of legislation that my colleague Dr. Coburn and I have introduced this session, and the Health Insurance Bill of Rights Act which Congressman Dingell introduced a couple of days ago.

Specifically I am pleased that the President's plan includes stepped up monitoring of managed care plans to ensure that seniors are not subject to health screening and preexisting condition limitations and protects seniors from higher out-of-pocket costs by prohibiting balanced billing Similar to the Medicare Patient Choice and Access Act, which Dr. Coburn and I introduced, the President's plan also requires Medicare HMOs to establish credible grievance review and appeals processes and provide clear and accurate information on a patient's rights and a plan's restrictions.

With that in mind, I believe that more can and should be done to ensure that Medicare patients are able to see the doctor of their choice and that managed care plans are prohibited from restricting communications between a patient and the doctor, whether they have coverage through their job, through Medicare or through Medicaid.

I am hopeful that working in a bipartisan manner we can achieve these important goals this year.

While the American Association of Health Plans argues against regulating managed care body part by body part, these bipartisan patient protection initiatives address the real health care needs of Medicare beneficiaries.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Greenwood—for a brief opening statement.

Mr. GREENWOOD. Pass.

Mr. BILIRAKIS. Mr. Waxman.

Mr. WAXMAN. Mr. Chairman, I am pleased you are holding this hearing. I think we need to determine what is the appropriate reimbursement level for HMOs.

If HMOs have a healthier population than the average Medicare population, then they are going to be over-reimbursed when we give them the average amount for the whole population under Medicare. To me we might want to look at ways to deal with the problem by getting a better case mix adjustment or perhaps rethinking the link with payments in the fee-for-service system.

I don't have the answer. The purpose of a hearing is to get input and I am looking forward to learning the views of all the witnesses today.

Thank you for holding the meeting.

[The prepared statement of Hon. Henry A. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you, Mr. Chairman.

I'm pleased we are having this hearing today. In my view, the proposals in the President's budget to make changes regarding payment levels for managed care are among the more difficult and complex that we face.

We have known for some period of time that our current way of reimbursing HMO's has not provided the Medicare program with the savings that we had hoped for. The testimony we will hear from the GAO today will once again reach this conclusion.

But one of the primary reasons this seems to be true is because payments based on the AAPCC, the Adjusted Average Per Capita Cost, result in paying more *on average* than what the people who are enrolled in HMO's cost. This seems to result because people enrolled in HMO's *on average* are healthier than the average Medicare beneficiary in the fee for service system.

To me, that argues that the way to appropriately deal with this problem is to get a better case mix adjustment, or perhaps rethink the link with payments in the fee for service system.

I don't know the answer, but I do know what I am concerned about. I don't want to see payments established at a level that an HMO that is serving a population as sick as the average in the area—or even more in need of health care services—is not paid enough to provide quality care and the extra benefits like drug coverage that enrollees have and expect to continue to have.

Some HMO's might have healthier than average populations. Some of them might have engaged in marketing practices to achieve this result. But we have to be careful that by freezing payments across the board—and lowering the percent of the AAPCC we pay—that we are not penalizing those HMO's who own enrollee population is not healthier than average.

Certainly we do not want to increase the incentives to avoid enrollment of sicker, higher cost beneficiaries.

We have to proceed carefully here. And I look forward to hearing from our witnesses today for the insights and help they can give us with this problem.

Mr. BILIRAKIS. I thank the gentleman from California.

Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, for calling this hearing.

For more than a decade Congress has attempted to create savings in the Medicare program by capturing efficiencies from the private market and I will look forward to your testimony, Mr. Fried.

The belief has been that managed care can offer seniors the same array of benefits that are available in the fee-for-service program but at a lower cost and I believe that we are going to hear evidence today however that the results point in the opposite direction.

Without adequate mechanisms to account for selection biases in Medicare managed care, the program is losing hundreds of millions

of dollars each year. One of the witnesses today will peg that figure at $2 billion alone last year.

There is now wide agreement in Congress that we should significantly modify the payment formula to capture some of those savings. I am pleased that the President recognizes these problems and has proposed significant reform in this budget. From the documents available, it looks like the President chose liberally from similar provisions that were included in the Balanced Budget Act of 1995.

Convinced of the need to address the disparities in the AAPCC payments across the country, I helped write those sections. I am glad that our efforts to craft a minimum payment floor and a formula to blend local and national rates have been revived in the administration's plan.

In fact, the President's proposal includes some new and noteworthy twists, including a carve-out of the GME and DSH money from the AAPCC and an overall reduction in the amount of the AAPCC to be paid to health plans.

Now as you know, these formulas are very complex and minor adjustments in one area can result in big impacts in other areas.

This morning HCFA provided me with the formula runs that detail how the President's proposals will adjust the rods and levers that make up the AAPCC and how it will affect each county in America. After a brief review, I can say that there are some signs of hope. The national floor of 350 will immediately help those who have lagged far behind the national average and the blended rates will help close the gap between high and low counties.

But I am concerned about the proposal to reduce the risk adjustment from 95 to 90 percent of the AAPCC. As I have previously pointed out, there is no risk selection in Iowa—my home State—because the AAPCC is so low that there isn't any Medicare managed care, and yet the risk adjustment in the year 2000 will actually reduce the monthly AAPCC for several counties in my district.

I will proceed with questions because I think that we should probably look at whether that adjustment should apply to those counties that are in the lower 50 percent.

I have a couple other questions about the carve-out.

The way the carve-out is done may actually end up rewarding HMOs. The money is carved out of the AAPCC and paid directly to teaching hospitals, but the HMOs are held harmless, so this is a deal that pumps millions of dollars into the teaching hospitals without taking it from the HMOs who were supposed to pass that money through.

In fact, the HMOs in those areas effectively get to double-count that money: the GME is carved out and the HMOs can assume that in their negotiations with the teaching hospitals. It is especially curious that in some of those areas HCFA is planning on paying hospitals hundreds of millions of dollars for not training additional doctors, so these are some of the issues, Mr. Chairman, that I will be looking at and look forward to your testimony, Mr. Fried and those others that will be before us today. Thank you.

Mr. BILIRAKIS. Thank you, doctor.

I know that you spent much time with the committee and with others in the last Congress on this subject because it means so very much to Iowa.

The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, and I will try to be brief here.

For over 4 years now we have been advocating the need to bring the great differential between the urban and rural reimbursement rates and when we take a look at the fee-for-service Medicare program it uses economic index factors in order to try to represent the cost of providing health care, when HCFA created the original system, reimbursement rates, and now if you are going to use the same reimbursement rates for managed care then we analyze the cost for providing care in the fee-for-service program, the AAPCC if you will, if that one was flawed for the rural areas, then our concern is that the underlying payments for the fee-for-service, if that was flawed then these flaws are just to be transferred to the managed care reimbursement rate.

The underlying economic indexes used to create the reimbursement rates do not accurately reflect the cost of delivering health care in rural areas.

I want to read a letter, if I may, Mr. Chairman, sent by Neal Coburn, the administrator of the East Jordan Family Health Center to you, Mr. Fried. In his letter he just states, and let me just quote part of it—it was a two page letter, I just want to do part of it.

He says "The very substantial disparity in payments is simply too wide to justify on the basis of differential practice costs. When I hire physicians I must hire in a national market and pay them salary increments not unlike what was published in Medical Economics. My supplies are often more expensive than those purchased in urban areas where there is a greater competition and larger volumes being purchased.

Utility and transportation costs are greater. Rural construction costs are higher. Malpractice costs are usually the same on a Statewide basis.

Even hourly rates for technical personnel such as X-ray technologists are comparable since there is such competition for the few that are available in rural areas. In short, my observations of the cost differential in delivering health care and Federal remedies to date have neither defined the problem accurately nor brought about a proper solution."

Mr. Chairman, I would ask that Mr. Coburn's letter to Mr. Fried be made part of my statement and I look forward to your testimony, Mr. Fried, and hopefully we can discuss that a little further. Thank you.

Mr. BILIRAKIS. Without objection the opening statements of all members here and absent will be made a part of the record.

[The letter follows:]

EAST JORDAN FAMILY HEALTH CENTER,
EAST JORDAN, MI,
January 23, 1997.

BRUCE FRIED, *Director*
Office of Managed Care
Health Care Finance Administration
3-02-01 South Building
7500 Security Boulevard
Baltimore, MD 21244-1850

DEAR DIRECTOR FRIED: We met briefly at the National Association of Community Health Center's meeting in San Antonio. Although the discussion at the conference was primarily about Medicaid waivers and cost based reimbursement, I promised you that that was not the subject that I was seeking to discuss with you.

Having been involved in the delivery of health care services in rural areas for nearly 20 years, I have had a continuing interest in the impact of Medicare formulas on the distribution of Medicare payments in rural versus urban areas, and in particular in very highly paid metropolitan areas versus very poorly paid rural areas. I was in regular correspondence with the Medicare Physician Payment Review Commission shortly after it was formed. I had great hope for change when Congress passed legislation requesting that actual cost surveys be made of practice costs in the various payment districts. Beyond this, it also allowed for the option of statewide payment districts. Unfortunately, in lieu of doing so, the Congress has allowed the use of economic proxies that look surprisingly like the Medicare economic index factors that were used prior to the passage of the law. As a result, extremely large disparities continue between large metropolitan areas and rural areas in the distribution of Medicare resources.

Although it is the intent of the economic proxies to reflect the differential in the cost of practice, in my experience it does not appear to do so. The very substantial disparity in payments is simply too wide to justify on the basis of differential in practice costs. When I hire physicians, I must hire in a national market and pay them salary increments not unlike what is published in Medical Economics. My supplies are often more expensive than those purchased in urban areas where there is greater competition and larger volumes being purchased. Utility and transportation costs are greater. Rural construction costs are higher. Malpractice costs are usually the same statewide. Even hourly rates for technical personnel such as x-ray technologists are comparable to urban areas since there is such competition for the few that are available in rural areas. In short, my observation of the cost differential in delivering health care and the federal remedies to date have neither defined the problem accurately nor brought about a proper solution. It would appear that the economic index that has been used in the past and the one that is presently being used primarily pays economically wealthy areas wealthy payments and economically poor areas poor payments, even though the Medicare recipients paid the same tax rate, regardless of where they lived all their lives, but they are allotted far fewer resources to support an adequate medical establishment for their needs.

Even though this payment methodology was regionally established to adjust fee for service payments, the methodology extends to managed care, because the area adjusted per capita cost index used by Medicare to establish the capitation rates is based upon the historical fee for service payment rates in each defined payment area. In effect it becomes a shadow adjustment of the historical fee for service payment inequities. As a result, those economically strong areas that had very high reimbursement under the old economic proxies continue to have very high capitation rates versus the very low capitation rates paid to economically poor areas of the country. This is well known by the HMO's. I have gone to conferences in which they have projected maps on the wall showing Medicare's very high payment areas and lectured on the proper placement of HMO development to maximize profit for their investors. Under a system with such disparity of payments there is no interest in delivering services to economically poor areas with poor Medicare payments. Since Medicare is a program that is supposed to be providing medical services to American Citizens over the age of 65 or with disabilities, it would seem that its purpose would be to provide resources in a much more equitable manner.

I have witnessed many congressional hearings regarding the payment system. All too often when the inequities are discussed, it is noted by at least one member that the committee needs to review what the impact of the reforms would be on each of their districts. Since we are primarily an urban nation, there is great concern that a reduction in payments to an elected representative's district would also result in a reduction of their political capital. This a logical outcome of an elected rep-

resentative government. Therefore, the rate of reform has been very incremental and slow.

I would suggest that a much more effective instrument of change would be the marketplace. Presently, the marketplace is substantially undermined by over 200 very small, predetermined payment districts. In order to increase flexibility, I would suggest that HCFA consider awarding HMO contracts only on a statewide basis. It would then be up to the HMOs and other managed care organizations to negotiate the value of each provider and to distribute the available premium according to the value of the marketplace. This would also make the managed care organization responsible for offering an appropriate package of services to all Medicare patients, regardless of the area in which they live. In this way, each provider would need to negotiate its value as a provider with the managed care organization and the managed care organization would need to develop the necessary contracts to make an appropriate managed care program available to all Medicare recipients in the state. I would hope that you would consider this to be the kernel of an idea that might be able to solve the chronic problem of maldistribution of payments and premium as well as substantial differences in Medicare patients' access to health care.

I believe that there is opportunity to overcome many of the historical impediments to reform through managed care contracting, utilizing the power of the marketplace to establish appropriate value and distribution of services. I also believe it is apparent that it would not require additional cost and it would not have serious political impediments. I hope that you would find some merit in this idea. I would appreciate your thoughts on this matter.

Thank you for your time and consideration of this matter.

Very truly yours,

NEAL G. COLBURN,
Administrator

Mr. BILIRAKIS. Dr. Norwood for a brief opening statement.

Mr. NORWOOD. Thank you, Mr. Chairman. I am particularly pleased to see that we are beginning the 105th Congress with a hearing on managed care, and I understand that this hearing will discuss payment methodologies for Medicare managed care. But it is my hope, Mr. Chairman, that this will be the first in a number of much-needed hearings to discuss various issues in managed care for the private sector.

Mr. Chairman, I know that you understand the significance of these issues and I really truly look forward to working with you and my colleagues to hold meaningful and comprehensive and fair hearings on managed care this year.

I also want to take this opportunity upfront to thank Mr. Fried for getting his testimony to us 2 days before the hearing. It is duly noted and appreciated and I hope this trend will continue as members of the administration testify before this committee. I believe this will make for much more informed and intelligent discussion of the issues at hand.

Mr. Chairman, I continue to be a strong supporter of increasing the choices available for Medicare beneficiaries. Giving senior citizens credible choices in their health care includes allowing them to select managed care, but also medical savings accounts, provider sponsored networks, or indeed traditional fee-for-service.

It also means treating them like adults and recognizing that there are some things better done by individuals with their own best interests in mind, rather than politicians and bureaucrats who think they know every time what the American people want.

To that end I do applaud the administration for moving toward offering greater choices for senior citizens including the use of PSNs.

I have been a strong supporter of PSNs and believe that we must pursue alternatives to managed care and other options available to Medicare beneficiaries.

I also want to congratulate the administration for their efforts to improve the quality of Medicare managed care services. Managed care typically relies on under-utilization of services and the ability to narrow or limit services for the sake of controlling cost, and to that end we must find somewhere a happy medium where health care services are properly utilized and costs indeed are kept in check.

Certainly nonprofit managed care companies should have a right to make a profit but we must proceed in this with caution. If exorbitant profits come at the expense of quality health care for the patients then Congress must consider some basic guidelines to protect patients in a managed care environment and that is indeed what HCFA has done, and I applaud you for your efforts.

We must indeed recognize one thing though—the same protections that exist for Medicare managed care beneficiaries do not exist for those enrollees certainly in ERISA plans and in some cases non-ERISA plans. Placing consumer protection requirements in Medicare makes managed care more attractive to seniors which have some hesitation about joining Medicare HMOs.

Requiring the same or similar protections in the private sector would also I think put people at ease, where enrollees often do not have the same choices available to them as Medicare beneficiaries do.

I truly look forward to engaging in a discussion today of the impact of these consumer protections for Medicare beneficiaries as well as the issue of reimbursement for Medicare managed care plans.

Mr. Chairman, again I thank you very much for holding this hearing and I am looking forward to this afternoon very much.

Mr. BILIRAKIS. And I thank the gentleman.

The gentlewoman from Oregon, Ms. Furse.

Ms. FURSE. Thank you, Mr. Chairman. I am going to submit my statement but I would just like to touch on a couple of issues.

This is something that is extremely important to Oregon and I am so glad, Mr. Chairman, that you are having this hearing. In fact, for our health care it's probably one of our top concerns.

It is my belief that the current methodology actually punishes Oregon because we have a more efficient competitive health care market. As most of you know, Oregon has enacted a number of initiatives and reforms and as a result our State has a higher percentage of Medicare beneficiaries under HMOs but under the current system we really do not do as well as States who have a higher cost per patient or who have higher fraud costs. We need a change and it should also be noted that we don't have as wide a list of benefits under our health care plan and so somebody in, say, California who has a relative in Oregon is concerned why—why do we not have those, and that is one way we have kept our costs down.

I applaud the administration for recognizing the need to change the AAPCC, but I am concerned that while the blending proposal certainly narrows the variation, it may leave the job unfinished. We would like to work very closely with the administration to

make sure that Oregon, which has gone out of its way to make these reforms to make this efficient, that Oregon in fact benefits from the changes, and I look forward to Mr. Fried's testimony.

Thank you, Mr. Chairman.

[The prepared statement of Hon. Elizabeth Furse follows:]

PREPARED STATEMENT OF HON. ELIZABETH FURSE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Mr. Chairman, members of the Subcommittee, I am delighted that we are having a hearing on this issue today. Of all the issues that we face in Oregon on health care matters, this is one of our top concerns. I have had numerous discussions with health officials in Oregon regarding the existing payment rates for Medicare managed care organizations, and it is my belief that the current methodology actually punishes Oregon for having an efficient, competitive health care market.

As most of you know, Oregon has enacted a number of innovative reforms over the years. As a result, our state has a high percentage of Medicare beneficiaries enrolled in HMOs. Under the current system, the Adjusted Average Per Capita Cost (AAPCC) actually rewards states which have high rates of fraud and, conversely, punishes states like Oregon which have systematically worked to reduce their costs. This must change. There is also a wide variation in terms of benefits. I constantly hear from my constituents who have friends or relatives in high-spending states who have access to dental, vision, or other services which are not offered by Medicare HMOs in Oregon. While I am less certain on how to approach this problem, it also must be addressed.

While I applaud the Administration for recognizing the need to change the AAPCC—particularly the blending concept and the establishment of a floor of $350 in payment rates—I have a number of questions about their proposal. I am concerned that while the blending proposal certainly narrows the variation in the existing AAPCC methodology, it may leave the job unfinished. There are also a number of other questions pertaining to benefits and graduate medical education funding which I hope are fully discussed today.

I thank everyone for taking the time to come before the Subcommittee today, and look forward to working with everyone on this Committee to resolve this very significant problem this year.

Mr. BILIRAKIS. And I thank you. Mr. Whitfield for a brief opening statement, please.

Mr. WHITFIELD. Mr. Chairman, I also thank you.

We enter these hearings with great hope and expectations of providing a more efficient Medicare system, better quality, lower cost, and I know that historically that has always been the aim and it seems like that every time whatever we do, whether we adopt a DRG system or disproportionate share or whatever, it ends up costing more money.

So while we have the expectation of hope, we come to this with a dose of reality as well, and I would just say that some statements have been made about HMOs not being able to provide care at low cost and I think that they can provide care at low cost but the formula that is used to reimburse the HMOs I think obviously there's something wrong with it, because I guess the only calculation involved there is the fee-for-service cost, and that is used, but we look forward to your testimony and hopefully we can come up with a good solution to this problem. Thank you.

Mr. BILIRAKIS. I thank the gentleman.

The gentlewoman from California, Mrs. Eshoo.

Ms. Eshoo. Thank you, Mr. Chairman, and most especially for holding this important hearing, which I expect will be a real educational experience because we are dealing with a lot of complexities.

Understanding Medicare's managed care payment rates as they are currently structured is I think a worthy challenge, and I have to say that having reviewed the President's proposed changes to this payment, I don't envy you, Mr. Fried's, job of explaining these proposals today.

I do want to commend the administration for its recognition of the importance of graduate medical education and disproportionate share funding. We should ensure that these funds are spent for the purposes for which they are intended and not as bonuses for managed care companies, and I think that there is a very important distinction to be made there.

Obviously the bottom line is that managed care is an important part of the Medicare system. I have many constituents that have enrolled in such plans. Many of them are pleased with them. There are other constituents that are deeply suspicious of them, so whatever we do we need to do well in order to attract people into the systems and hopefully that they continue to be good for people well into the future.

With over $33 billion in savings from managed care being proposed by the administration, it I think is one of the most important parts of the budget.

I did say in a hearing that we had last week that it is critical that we evaluate reforms to the system. Certainly we are trying to save money everywhere. I think perhaps all too often when cuts are made they are called reforms.

It is important to underscore that there is a difference between the two, so the opportunities that we have to reform systems and also to save money I look forward to hearing about, and I look forward to your testimony.

Thank you again, Mr. Chairman, for holding the hearing.

Mr. BILIRAKIS. And I thank you. Let's see—Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman, I, too, thank you for this hearing and thank our witnesses who are attending today. I noted in the testimony that enrollment in managed care programs has grown about 30 percent. I think that part of that increase is no doubt that they are attracted by the extra benefits that managed care programs can offer, whether it be prescription drug coverage, Medigap insurance, or some other things that you cite in your testimony.

I represent southwestern Michigan. My other colleague from Michigan, Mr. Stupak, represents all of the Upper Peninsula and a good chunk of the Lower Peninsula as well. There is not a county in our districts whose adjusted average per capita cost-based payments even equal the average rate. Some of my colleagues have talked about the AAPCC rates—something that I am very concerned about too.

In my district, our rates are all between 10 and 20 percent below the national average. We look over at what Detroit, and some of the other areas around the country and see that they are 31 percent or more higher than the national average. In my understanding there is almost even greater than a 250 percent disparity between some areas in the country and others. As we look at trying to get some fairness, as I talk to my constituents, this disparity is amazing.

I had a fellow come up to me this last year who went down to Florida, Mr. Chairman, and the bills that were submitted to Medicare from there versus the procedure that he had done in Kalamazoo were thousands of dollars different. He happened to go down—one of my snowbirds—and the difference was just amazing. So as we try to get some fairness and reality into this system obviously we are going to have to work on the AAPCC rates and other reimbursement and coverage issues because the system today is not the way that it ought to be.

It's not fair and equitable.

I have seen just today some of the new numbers that Mr. Ganske referred to, and they are not good enough either, so I look forward to your testimony and working with you in the next 2 years.

Thank you and I yield back my time to my good friend from Florida.

Mr. BILIRAKIS. I thank the gentleman and that is why we are here, of course, to look into these things.

I think a real testament to the significance of this issue to this committee is the fact that we have such a turnout here today.

The last vote has already been cast for the week and ordinarily people are already on an airplane flying out of here and just the fact that they are here is—but I am trying to cut these opening statements down though so that we can get rolling.

Let's see—I guess—did I see Mr. Green come in?

Mr. GREEN. Yes.

Mr. BILIRAKIS. Opening statement, brief?

Mr. GREEN. Mr. Chairman, I'll submit it to the record.

Mr. BILIRAKIS. Without objection. That's very nice of you. Let's see—Mr. Burr.

Mr. BURR. Mr. Chairman, I share the concern of my colleague from Michigan, Mr. Upton. I am a nonresident owner of property in Michigan and I have complained vehemently to the Governor about the price I pay for property taxes versus those residents of Michigan. Life is not always fair but we do have rules we live by.

It was suggested earlier that we should be suspect any time a plan exists that offers more benefits, benefits that we don't think they can do for the cost that they are reimbursed.

Seniors are attracted to these plans because they need these services. That is what is great about the free marketplace.

I don't believe that our job is to target or punish people who in fact find new ways to become efficient. I am hopeful that every company that offers a service strives for that every day.

The questions that I ask myself as we sit here and we go through these months of hearings on the administration's proposals and our own will be: Are we working toward the bigger picture of how we save Medicare? Are we encouraging the creation and growth of new and existing options for seniors?

You see, if we judge everything based upon cost alone, then I think we can go to any community in this country and we can find health care delivered to seniors free. It's not abundant but it exists.

If we are not conscientious, options will exist but they won't be abundant, and I think that is the balance we have to be conscious of as we begin these hearings and as we work through the process.

I thank you, Mr. Chairman. I yield back.

Mr. BILIRAKIS. And I thank the gentleman. Let's see—Mr. Strickland, I believe.

Mr. STRICKLAND. No opening statement, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Ted. Mr. Bilbray.

Mr. BILBRAY. Just quickly, Mr. Chairman, let me just echo the gentlelady from Oregon's concern that those of us who are trying to be innovative and bring costs down, seem to be getting caught in the crossfire here and frankly in California, where you have 37 HMOs, 70 preferred provider organizations—in fact, in San Diego over 83 percent of our citizens either participate in HMOs or PPOs—when you take a look at the fact that in California the Medicare population has 36 percent in some kind of managed care, as compared to 13 percent nationally, then when the administration starts proposing taking the benefit package and reducing it, it does not place an equal burden across this country, and to be very blunt with you, I know the administration doesn't mean to be punitive against the West.

I'm sure of that, but when you look at what has been in this budget proposal, the elimination of reimbursement for emergency health care to illegal aliens, the DSH payments, the cap on growing States, and not recognizing our reduction in cost, someone who didn't know better would think there is a punitive attitude here, and frankly I look forward to finding out how you plan on addressing the fact that a State that the President cherishes, spent a lot of time in the last 2 years in, I am looking for answers from this administration that you are not forgetting everything that was said in the last 2 years to the people of California.

Thank you, Mr. Chairman, I yield back.

[The prepared statement of Hon. Brian Bilbray follows:]

PREPARED STATEMENT OF HON. BRIAN BILBRAY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, I want to thank you for conducting this hearing today on Medicare Managed Care. I look forward to hearing the testimony this afternoon on the payment of this program.

The President's proposal to cut the reimbursement figure from 95% of the Adjusted Average Per Capita Cost (AAPCC) to 90% is somewhat troubling due to the fact that it would penalize all health maintenance organizations (HMOs) equally, which is unfair to those who are operating efficiently and saving money for the government.

In addition, I am also concerned about this proposal due to the fact that California has such a high concentration of managed care providers and recipients, as compared to the rest of the nation. California is served by 37 HMOs and 70 preferred provider organizations (PPOs). In San Diego County, over 83% of our residents either participate in an HMO or a PPO, while a little over 16% are enrolled in traditional insurance. In regards to Medicare, in California, 36% of Medicare beneficiaries are enrolled in managed care, as compared to the national average of just 13%. In San Diego County, the percentage is even higher, with 46% of all Medicare beneficiaries enrolling in managed care.

Along with the overall level of satisfaction Medicare beneficiaries have for their managed care plans, Medicare payments also have increased at a lower rate in California than the U.S. average. The average individual premium per month for California is $290.58, compared to the national average of $301.33. The number of Medicare beneficiaries in prepaid plans is also greater, and has been increasing faster in California than the national average. In spite of this, between 1994–95, the Adjusted Average Per Capita Cost (AAPCC) in major California counties increased at slower rates than the U.S. average.

Medicare beneficiaries should be able to exercise the same range of choices to which the private sector currently has access. Beneficiaries should have the same options available to them, such as traditional fee-for-service and all variations of

managed care. The only way to effectively slow the rate of growth of Medicare and to preserve this important program for today's seniors and for future generations is to offer them considerable choices.

It is this kind of saturation into the marketplace that I believe affirms the credibility of the overall satisfaction rates. A Mathematica Policy Research study shows that the better coverage and lower cost of HMOs contributed to high rates of member satisfaction, with 93% of HMO members stating that they would recommend their HMO to a friend.

I have received numerous responses from seniors who want to remain in their current managed care policy. I believe that we must continue to allow more HMOs to expand into markets to provide additional services to seniors. One way of doing this could be to expand managed care options to include PPOs and Provider Sponsored Organizations (PSOs).

Once again, Mr. Chairman, thank you for holding this hearing. I look forward to hearing the testimony of the witnesses on this complicated issue, and I yield back the balance of my time.

Mr. BILIRAKIS. And I thank the gentleman.

Let's go right on to the panel, which consists of Mr. Bruce Fried, who is Director of the Office of Managed Care with HCFA here in Washington, and Mr. Fried is a graduate of the national football champion University of Florida Gators.

Without any further ado, Bruce, I am not going to turn the clock on but I would appreciate if you could limit it to maybe 10–12 minutes, something to that effect, and any additional time you may need we'll either consider or you may be able to put it in during the questioning.

Please proceed, sir.

STATEMENT OF BRUCE M. FRIED, DIRECTOR, OFFICE OF MANAGED CARE, HEALTH CARE FINANCING ADMINISTRATION

Mr. FRIED. Thank you, Mr. Chairman. It's a pleasure to be here today. I have submitted a fuller testimony that covers not only the payment issues that I know we are all interested in talking about, but also the significant amount of work that is both proposed and under way for the administration in terms of quality of care, beneficiary protections, and other issues that are critical to the success of managed care as a delivery system in the Medicare program.

Mr. Chairman, I am very pleased to be here to describe how the Health Care Financing Administration is working to make high-quality, right-priced managed care a real choice for all Medicare beneficiaries. Increasingly we are working to use our significant market presence as the largest purchaser of health care as a beneficiary-centered purchaser of health care. We aim to give as many Medicare beneficiaries as possible the choice of competing health care plans and systems of care and to effectively use market forces to obtain the highest quality of care at the best price.

As was noted earlier, as of February 1, more than 5 million Medicare beneficiaries had chosen managed care over the traditional program. We are contracting as of that date with 358 managed care organizations, two-thirds of which are risk contractors. These are contractors who accept the capitated payment on a monthly basis to provide the full range of benefits under the program. Risk plan enrollment grew last year by more than a million beneficiaries.

I think this significant growth is attributable in large part to the growing competition among health plans and to beneficiaries who,

acting as rational economic consumers, are finding that managed care offers superior value in this competitive health care market.

In many cases enrollees can receive the same financial protection afforded by Medicare supplemental or Medigap insurance policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program such as routine vision care, dental care, preventive benefits, and prescription drugs at little or no additional cost to the beneficiary.

The President's proposals, both payment and programmatic, as well as ongoing administration activities, seek to expand competition, broaden health system choices for beneficiaries, achieve increasing value both in terms of quality and price, and afford the beneficiaries the highest level of consumer protection. At the same time, they achieve savings to sustain the Medicare program and to contribute to a balanced budget.

The President's plan addresses three concerns that have been raised with regard to the current method of paying Medicare managed care plans under a risk contract. I think in the service of a full explanation it might be helpful to lay out the context of these issues and then come back to the specifics. It has been noted by several members of the committee that these are complex proposals. They have an interactive effect on each other. We have a chart here on the easel and in your materials that, I think, may help you understand the context.

The President's plan addresses the wide variation in payments among plans. It was noted that the range is greater than 250 percent. The current methodology results in payments as high as $767 per member per month in the highest-paid counties, and as little as $221 per member per month. I am happy that Dr. Ganske made the observation that the administration has adopted, in significant part, the very thoughtful recommendations that were proposed and adopted by the Congress in the budget bill of 1995. Both use a strategy of a floor, a blended rate, and another methodology, which I will talk about, to substantially narrow the gap.

There is a bar chart there that may be worth looking at for a quick moment. The red portion of the bar chart notes the current spread of payments among the counties. You can see that at the extreme left there is a fairly low level. That would be the lowest-paid counties. And then over toward the right we have a number of counties in a very high range.

Under the President's proposal, the range of payments is substantially narrowed to the mean in a way that affords significant increase in payments to plans in low-paid counties, and again, we will go into that in more detail.

Specifically one of the consequences of our being able to improve payments to low-paid counties will be to make managed care a viable possibility as a business matter for health care plans in areas of the country where managed care simply could not make a go of it given our current payment strategies. In our estimation, this result alone extends choice and competition in ways that will have significant salutary benefits for not only beneficiaries in those counties but for the entire system.

The second area that the President's plan addresses is the so-called "carve-out" of the medical-education and disproportionate-

share payments. As you know, there has been growing concern as to whether plans are properly spending that portion of their payment that is for medical education and disproportionate-share hospitals. Within the AAPCC for every county there is a portion of the payment that represents funds that are available in the fee-for-service program for graduate medical education and for disproportionate-share hospitals. There are growing concerns about whether plans are properly passing those funds through to those eligible institutions. Our proposal addresses these concerns by directly paying appropriate institutions when they provide care to managed care beneficiaries instead of passing the money through the plan. We can talk about that in more detail as well.

Finally, there is a strong and growing body of persuasive research that the administration is overpaying Medicare risk contractors as a result of favorable selection. Favorable selection is the phenomenon of plans attracting and enrolling beneficiaries who are, on average, healthier than the general Medicare population. Since our payments are based on the average Medicare beneficiary, to the degree that favorable selection occurs, clearly we are overpaying for those beneficiaries.

HCFA and most other researchers agree that we are overpaying plans by about 5 percent. We propose, therefore, to reduce the current overpayment to plans.

As you will see, since each of these problems is being addressed within the budget period, they have an interactive effect. They are moving parts which affect each other.

I will walk through these interactions now with a little more detail and with reference to the chart up on the easel and in the materials that you have. Perhaps that will provide a little more illustrative information about how our proposals function and how they work together.

First, about the blended-rate methodology. The budget would dramatically reduce the current wide geographic variation in payment rates to managed care plans by breaking the link between plan payments and the local fee-for-service payment experience.

The blended-rate methodology proposes to pay plans the greater of a blended national and local area rate or a minimum rate. The minimum rate would be the lower of $350 per month or 150 percent of the 1997 AAPCC. The reason we have those two together is that some counties would have had an extraordinary windfall, particularly in the territories, and it was our estimation that a 150-percent increase from the previous year was a very healthy increase. But virtually every county in the country will realize at least the $350 floor. So there is at least that payment.

Or payment may be based on a blend of the national average rate and the AAPCC or the local area rate. Currently as you know we pay 95 percent of what it costs us to provide Part A and Part B services to the average beneficiary in each county in the United States, the AAPCC. We propose to begin to blend, over the 5-year budget window beginning in 1998, by paying 90 percent of the local rate and 10 percent of the national rate, and then in 5-percent increments to reach a payment ratio of 70 and 30 in the year 2002. So we now have either the floor or the blend.

The third aspect of this is the minimum adjustment. There are some very highly paid counties in the country which even with these payment methodologies would be paid at above that level. We did not want to jeopardize or punish plans in these very highly paid counties by actually reducing their payments, and so for the period 1998 and 1999 we propose to hold them harmless with a zero update. We would not give them an increase and not penalize them. In subsequent years, in 2000, 2001, 2002, we would provide these plans with a 2-percent update. The payment then becomes the greater of those three—the minimum payment, the blend, or the minimum update.

Perhaps it would be helpful to walk through the chart. We have a chart on the easel, but you have the same one in front of you.

What we have done here is picked six counties that we felt were illustrative. Just by happenstance we picked Hillsborough, Florida, and Lorain, Ohio. They seemed to be representative.

Clearly Adams, Nebraska, begins in 1997 at a very low payment rate, $260.46. You can see the effect of the minimum-payment methodology. In 1998 Adams enjoys an immediate increase to the floor of $350 per month. In 1999 Adams receives an update that reflects the growth in Medicare per capita costs and also begins to see the effect of the blend.

You can see in 1998 the blend kicks in at $90.10. In 1999 it is at $85.15. In the year 2000 we take out 5.3 percent as the favorable adjustment, favorable risk adjustment. And so for that 1 year there is a less than 0.6 percent decrease in the plan's payments. In the year 2001 the plan enjoys, or the county enjoys, another update of the average Medicare per capita cost, as it does in the year 2002. In both of those years the blend kicks in in a fashion that also benefits that county, so that at the end of the 5-year window, Adams County, Nebraska, has enjoyed an increased benefit of 59.2 percent.

Now obviously this is a very small county, with 5,000 beneficiaries in it. But in this county that payment rate may make it possible for a provider sponsored network that will be up and running at this point to afford to run perhaps a newly structured rural managed care system reliant on telemedicine technologies and provide the kind of management of health care that simply is not possible today.

Let me switch, if I could, to Hillsborough, Florida, Mr. Chairman. I know that would be of interest to you. You see that we start with Hillsborough being paid at a fairly moderate rate, $486.70. Included in that payment is 5.6 percent for medical education and disproportionate share hospitals. In Hillsborough County there are 86,000 Medicare beneficiaries. In the first year there is a small adjustment that reflects the blend. Hillsborough was just below the average. So there is less than 1 percent increase, but there's a little bit of an increase. Still with the blended payment and the benefit of the annual Medicare per capita adjustment in 1999, the payment goes up a little bit more than 1 percent. The payment continues to rise in 2000 and even in your instance with the removal of DSH payments and with the removal of the 5.3-percent favorable selection adjustment, Hillsborough County still has a small increase. The bottom line, you note, is that at the year 2002, Hillsborough

has benefited by an increased payment per managed care recipient of 17.4 percent.

Clearly among the most high-paid counties in the country is the Bronx, New York. Be that as it may, the Bronx starts at a very high level of payment, $728.24 a month. It has significant medical education and disproportionate-share payments, more than 25 percent. In 1998 we start by taking out the GME/DSH adjustment. In that year there is a 50-percent reduction of the total GME and DSH payment. These payments are in 1999 and thereafter.

The county is sufficiently highly paid that in both 1998 and 1999 it has no increased benefits from the zero premium hold harmless provision. In the year 2000, the adjustment for favorable selection is taken out. The county realizes a better than 3-percent reduction. And then in 2001 and beyond it is on the 2-percent hold-harmless update until about 2002 when it has closed the gap and begins to enjoy the benefits of the standard Medicare per capita adjustment that all plans would realize.

Let me say one word, if I could, about the GME/DSH.

Mr. BILIRAKIS. Why don't you sort of summarize, maybe take another couple minutes, Mr. Fried.

Mr. FRIED. I would be happy to do that.

On the GME/DSH issue, while we are taking money out of the AAPCC payments, that projected savings of $10 billion the savings appear in the managed care portion. Those moneys are not lost to the system. As I mentioned, the hospitals are paid directly at the time of discharge of a Medicare beneficiary enrolled in a managed care plan instead of receiving their payment through the managed care organizations.

Clearly this changes the relationship between the managed care plan and the teaching or disproportionate-share institution, and we would expect that that change of relationship would be taken into account as those organizations negotiate their new contracts with the managed care plans.

Mr. Chairman, let me see if I can just summarize the remainder of my testimony. I have covered the payment. We can spend more time talking about it. I am sure we will. But obviously part of the President's programmatic proposal that accompanies this is the proposal to begin to enter into relationships with physician hospital organizations, provider sponsored networks, and preferred provider organizations. The administration feels strongly that Medicare beneficiaries ought to enjoy the broadest array of choices. You may know that we are already experimenting with PSN's through our demonstrations, and we propose to be able to do business directly with them on an ongoing basis.

The last thing I would say, Mr. Chairman, is that this is not the end of the process as far as we are concerned. What we have proposed addresses a number of the significant problems that exist with the AAPCC, but I also want the committee to understand fully that we are fairly far down the road in experimenting with alternative payment methodologies that I think have already been mentioned in the opening statements.

In a number of our demonstrations we are testing risk adjustment payment strategies that will allow us, we think, very early in the next century, perhaps as early as 2000 or 2001, to come back

to Congress with a different payment methodology that will allow us with great precision to make payments to plans in ways that reflect both local market conditions and the health risks of specific patients.

In addition to experimenting with that, we hope to launch an experiment in the Denver area to actually test how the market may work to help us set an appropriate payment level. In that instance, we are going to be conducting a competitive payment program where plans in that community will be asked to bid against a standard package of benefits. From those bids we will then be able to define an appropriate governmental payment that essentially reflects what the market will bear.

Obviously, Mr. Chairman, there is much more that we could go into. I am more eager to engage in the kind of dialog that I think we are all open to here, and I am happy to respond to any questions you may have.

[The prepared statement of Bruce M. Fried follows:]

PREPARED STATEMENT OF BRUCE MERLIN FRIED, DIRECTOR, OFFICE OF MANAGED CARE, HEALTH CARE FINANCING ADMINISTRATION

INTRODUCTION

Mr. Chairman, I am very pleased to be here today. I would like to describe how the Health Care Financing Administration (HCFA) is working to ensure that the availability of managed care options will enhance health care for Medicare beneficiaries. It is important that we clearly define and support measures to promote quality of care, not only for beneficiaries enrolled in Medicare managed care plans, but for all Americans in all types of health plans.

Managed care options have been a part of Medicare since the program's inception. With the signing of the first risk contracts authorized under the Tax Equity and Fiscal Responsibility Act in 1985, managed care plans proliferated and today have become an essential part of the Medicare and Medicaid programs. As of January 1, more than 4.9 million beneficiaries have enrolled in 350 Medicare managed care plans, two thirds of which are risk contractors. Risk plan enrollment for the first six months of 1996 increased by more than 520,000 beneficiaries—an annual growth rate of more than 30%. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent. Medicaid enrollment has shown an even more dramatic increase, with a hefty 51 percent increase in 1995. Currently, almost 13.7 million Medicaid beneficiaries are enrolled in managed care plans.

In a managed care plan, a network of doctors, hospitals, skilled nursing facilities and other providers offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in emergencies, services must be obtained from health care providers that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

We have found that the managed care option is attractive to many beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental—or "Medigap"—policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. I should point out, however, that the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology, which we have proposed to address in this year's budget. Beyond value measured in dollars and cents, managed care plans have the potential to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and "wellness."

Our mission in HCFA is to serve our Medicare and Medicaid beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not received by most commercial enrollees. Let me take this opportunity to outline briefly the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

- *Beneficiaries must receive clear and accurate information about the implications of their choice of a managed care option*—Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.
- *Beneficiaries cannot be subjected to health screening or preexisting condition limitations*—Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.
- *Beneficiaries must have access to medically necessary and appropriate care*—Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMOs adhere to these Federal standards.
- *Beneficiaries must have access to procedures to resolve grievances and access to a neutral third party for appeals*—While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.
- *Beneficiaries' care is reviewed both internally and externally*—Plans must have internal quality review mechanisms in order to receive a contract. PROs are responsible for external quality review. We have been working closely with other payers and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.
- *Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan*—Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.
- Beneficiaries' out-of-pocket expenses are limited—Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have also been working toward enhancing beneficiary protections. Some steps can be taken under current law, while other actions would require legislation.

- *Improving the Appeals and Grievance Processes:* The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.
- *Unrestricted Medical Communication:* The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, Medicare beneficiaries are made aware of the full range of treatment options by their physicians. Managed care enrollees are entitled to the same advise and consultation. This is a basic right of the patient and we have communicated the prohibition against "gag" provisions in a policy instruction to all health plans.
- *Post-Breast Cancer Surgery Hospitalization:* The national attention given to coverage of mastectomies indicates that there is a need for greater oversight. We are committed to preventing sub-standard care in this area since Medicare pays for one-third of all mastectomies. By law, Medicare beneficiaries who receive mastectomies are entitled to coverage for all medically necessary care. The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12, 1997, we sent a policy letter to all managed care plans, making it clear that they may not set ceilings for inpatient hospital treatment or requirements for outpatient treatment. Similarly, we will soon be reinforcing this message in Medicare's fee-for-service sector.

- *Physician Incentive Plans:* Effective January 1, 1997, the Physician Incentive Plan Final Rule required managed care plans with Medicare or Medicaid contracts to disclose information about their physician incentive plans to HCFA or the State Medicaid agencies, before a new or renewed contract receives final approval. Plans whose compensation arrangements place physicians or physician groups at substantial financial risk must provide adequate stop-loss protection and conduct beneficiary surveys.
- *Prudent Layperson:* The Administration's plan clarifies the obligation of Medicare managed care plans to pay for emergency services rendered to their enrolles. By using HCFA's definition of "emergency services" as those services that a "prudent layperson" would reasonably believe to be needed immediately to prevent serious harm to the patient, States will be better able to determine similar requirements for commercial managed care enrollees.
- *National Marketing Guidelines:* To ensure uniform interpretation and provide beneficiaries with accurate and clear information about managed care plans, we have developed the Medicare Managed Care National Marketing Guidelines. These Guidelines, which will be released next month, were developed in cooperation with the American Association of Health Plans and representatives of the health care industry.
- *Beneficiary Information Publications:* HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.
- *Comparative Information:* We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's FY 98 Budget Plan, we propose that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Currently, many of HCFA's regional offices sponsor and disseminate comparative information for local beneficiaries. HCFA is currently working to implement a Competitive Pricing Demonstration in Denver to test a range of new education and information resources for beneficiaries—including new formats of printed materials, in-person seminars, and a 1-800 call center, all coordinated by a HCFA-sponsored third party. The goal of these resources is to help beneficiaries understand their options under Medicare and help them make the best choices—whether it is fee-for-service, Medigap, or managed care.
- *Community-based Medicare Information Resource:* This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall and is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also available, using technology such as interactive video-conferencing and computerized information kiosks.

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compli-

ance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements *before* we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties. The importance of consistent and conscientious quality monitoring cannot be overemphasized, and I would like to devote the rest of my testimony to describing the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, more elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for "under-service" and poor quality, if plans try to maximize short-term profits by not delivering appropriate care. The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. HCFA and the Agency for Health Care Policy Research (AHCPR) have been active in promoting research to identify these measures. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee-for-service, and to determine whether managed care is living up to its potential to improve the quality of care. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations, and with how to present this information effectively to beneficiaries.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payers to accelerate and standardize the development of outcomes measures.

- *HEDIS 3.0:* The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. As of January 1, 1997, HCFA is requiring Medicare managed care plans to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of

care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information.

HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the "effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.

- *Foundation for Accountability:* The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the FAcct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the ASPE also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.
- *Medicare Beneficiary Survey:* In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary survey. This survey quantifies Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1 of this year, HCFA is requiring all health plans to use CAHPS, which is now available to the public. HCFA plans to administer the survey through an objective single third party vendor in order to ensure comparability.

In addition to our quality measurement initiatives, we are actively involved in promoting quality improvement.

- Projects to Assess Ambulatory Care in Managed Care Settings: The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PROs in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.
- *Medicare Choices Demonstration*—An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project, we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100% encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs; we have similar quality improvement initiatives for Medicare fee-for-service plans. Our budget also includes a provision to give us the authority to develop an integrated quality management system, so that we can assess more comprehensively the quality of care provided under fee-for-service.

THE PRESIDENT'S 1998 PROPOSALS

Everyone agrees that "knowledge is power," but at no time has the dissemination of information been so critical to health care choice. Beneficiaries are often stymied in their health plan choices by an overload of esoteric and confusing information, making it difficult to determine which plan best meets their needs. We seek to empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand.

The President's 1998 Budget Plan includes several proposals affecting areas I have already discussed. We believe these changes are important to achieve our stated goals of preserving the solvency of Medicare and enhancing beneficiary protections and choices. Specific actions we have taken to expand and enhance beneficiaries' choices include:

Expanding Beneficiary Choices

- *Expanded PPO/PSO Options*—Currently, HCFA can contract with Federally qualified Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options—both managed care and Medigap. To help beneficiaries compare various plans, standardized packages for additional benefits offered by managed care plans and the Medigap plans would be developed. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. These Medigap reforms would require annual open enrollment, prohibit imposition of pre-existing condition exclusion periods, and prohibit differential premiums based on age or health status.

- *Annual Open Enrollment*—Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap. The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances—such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area.
- *Elimination of Pre-existing Condition Exclusions*—In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Mrs. Johnson and others during the last session and we look forward to working together toward enactment this year.
- *Community Rating for Medigap Plans*—Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an im-

portant goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

Quality Initiatives

- *Quality Measurement System:* The President's plan would authorize the Secretary to develop a system for quality measurement which would replace the current requirement that managed care plans maintain a "level of commercial enrollment at least equal to public program enrollment," which is often referred to as the "50/50 rule." In the interim, the Secretary could waive the 50/50 rule for plans in rural areas and for plans with good "track records" or in other instances the Secretary deems appropriate.

PRUDENT PURCHASING FOR MANAGED CARE PLANS

Through a series of policy changes, the Administration's plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor of $350 per member per month, would dramatically reduce geographical variations in current payment rates. The plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. An assessment of the impact of the President's Medicare managed care proposals should consider the plan as a whole—both the merits of the components that have a budget impact as well as other non-budget components, some of which were discussed above. It should also be kept in mind that Medicare per capita costs, upon which managed care payments are based, have grown over the past two years by approximately 16 percent, while growth in payments to plans on the commercial side have been virtually flat.

Proposals With A Budget Impact

- *IME/GME/DSH CARVE-OUT* (Five-year saving—$10 billion): Payments for indirect medical education (IME), graduate medical education (GME), and disproportionate share payments (DSH) would be carved out of the blended payment rates over a two-year period (50 percent in 1998; 100 percent thereafter) and provided directly to teaching and disproportionate share hospitals for managed care enrollees and to entities with recognized teaching programs. The carve-out of these payments does not represent a reduction in payment for managed care enrollees because these funds would be provided to teaching and disproportionate hospitals directly by HCFA for such enrollees.
  - Managed care plans can consider these funds available to such hospitals when they negotiate their rates.
  - A current law provision that requires non-contracting hospitals to accept the Medicare diagnosis-related groups (DRGs) amount as payment in full would be modified to require non-contracting hospitals to accept the DRG amount, minus the carve-out, as payment in full.
- *INDIRECT IMPACT OF FEE-FOR-SERVICE PROPOSALS* (Five-year saving—$18 billion). The budget proposes an update mechanism tied to overall Medicare growth. Therefore, policies that would affect fee-for-service providers would also restrain the growth of managed care payments.
- *FAVORABLE SELECTION ADJUSTMENT* (Five-year savings—$6 billion): Beginning in 2000, an adjustment would be made to payment rates to reduce Medicare's current overpayment, which results from managed care enrollees being, on average, healthier than beneficiaries who remain in fee-for-service. Research studies support basing payments on 90 percent of the AAPCC rather than 95 percent, to take into account this phenomenon referred to as "favorable selection." This adjustment would remain in place until a new health status adjusted payment methodology is implemented.
  - Some have argued that the extent of favorable selection documented by Mathematica Policy Research (MPR) in 1993 no longer exists. This perspective, however, is not supported by a recent HCFA study (HCFA Review, Summer 1996), which would justify payment at 87.6 percent of the AAPCC, or about 83 percent if we continue to pay managed care plans five percentage points less than fee-for-service.
  - In the last three years, the Medicare program has lost, at a minimum, $2.2 billion because of favorable selection into managed care plans, and over $1 billion in the last year alone.
  - HCFA is developing a new payment methodology that incorporates health status adjusters and that moves away from the current policy of ignoring dif-

ferences in utilization between managed care and fee-for-service in making payment to managed care plans. A proposal could be ready for Congressional action as early as 1999, with phase-in beginning as early as 2001. Payment at the 90 percent level would be consistent with payment levels anticipated under this new payment methodology.

- Competitive Pricing Demonstration—This demonstration will test a new market-based payment methodology as a possible alternative to the AAPCC method, in addition to offering new education and information resources to local beneficiaries. The Denver site will start in 1997, to be followed by two additional sites.

Proposals Without A Budget Impact

- *BLENDED RATE METHODOLOGY*—The budget would dramatically reduce the current wide geographic variation in payment rates to managed care plans by breaking the link between plan payments and local fee-for-service experience. The blended payment rates, minimum payment and minimum increase would be implemented on a budget-neutral basis.
  - *Impact on Relatively Low Payment Areas*—Managed care plans, now in relatively low payment counties, would benefit from the proposed blended payment rate. By 2002, 30 percent of their payment rate would be based on a higher national rate. In each year between 1998 and 2002, many of these plans would receive a "double update," with rates increasing due to both the national update and the transition to the 70/30 blend.
- *Impact of Minimum Payment Amounts*—The President's plan would create, for the first time, a national minimum payment amount which would significantly increase rates in isolated rural counties and could increase the number of managed care plans serving rural and other low payment areas, especially with the entry of Provider Sponsored Organizations (PSOs) into the Medicare program.

We have a few illustrations of the effects of our managed care payment reforms on rates in counties with various characteristics. As you can see, the impact on a particular county depends both on current teaching costs and on whether the county is currently receiving a relatively low or high payment. **[Chart #1]** The methodology would ensure that no county would receive a decrease during the 5 year budget window except in the year 2000. In 2000, almost two-thirds of counties (64%) would receive increases; the other counties would receive either no increase or a decrease no greater than 3.37%.

The net effect of the President's payment proposals is a balanced approach that achieves savings and significantly reduces current wide geographic variation **[Chart #2]**, while continuing the trend of increased enrollment in managed care. Our actuaries project that the combined effect of the managed care reforms, both the proposals with a budget impact and those without budget impact described earlier, would result in increases in managed care enrollment compared with present law. By fiscal year 2002, under the President's plan, 22.5 % of Medicare beneficiaries would be enrolled in managed care plans, compared to 19.3% under current law. **[Chart #3]**

CONCLUSION

We are aware that there is still much work to do in the area of quality improvement of managed care. As the managed care market further expands and evolves, we expect to reap the benefits of innovative payment, administrative and patient care strategies. Some of these have already been applied to our Medicare modernization efforts and will contribute to Medicare savings. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. In cooperation with Congress, the health care industry, and the research community, we will reach our goals—to extend the solvency of Medicare, and guarantee its existence for future generations of Americans. I look forward to working with you to accomplish these goals.

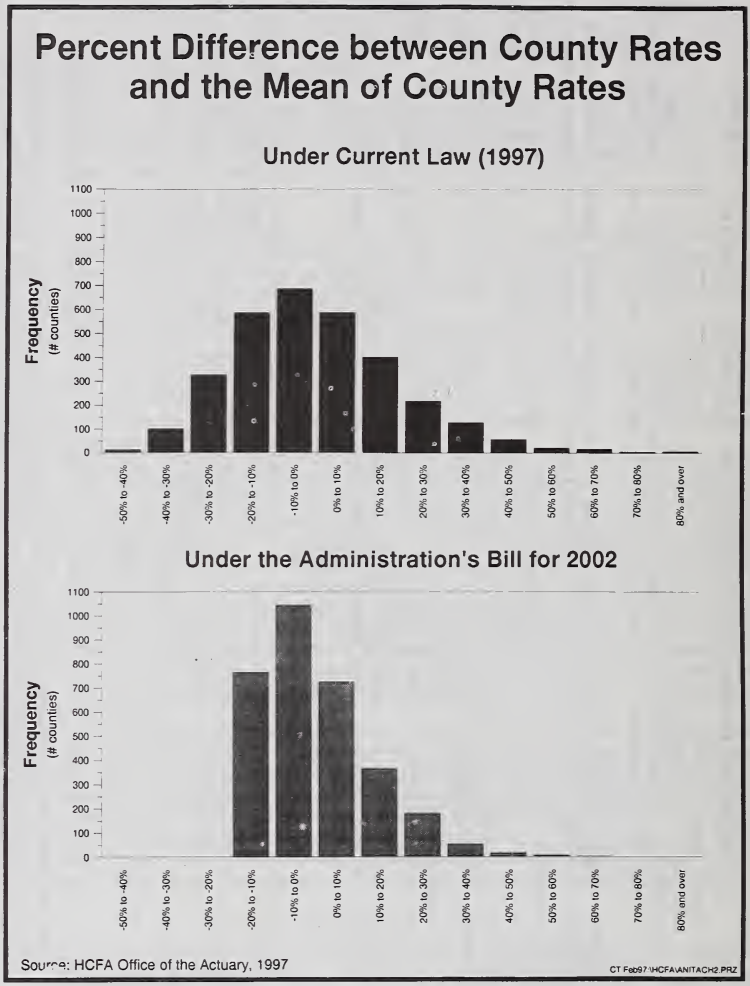
Chart 1

MANAGED CARE PAYMENT RATES UNDER PRESIDENT'S PROPOSAL -- EXAMPLES

Year (blend)	Adams, NE MedEd/DSH: 1.1% Medicare pop: 5K		Clackamas, OR MedEd/DSH: 5.8% Medicare pop: 33K		Lorain, OH MedEd/DSH: 3.2% Medicare pop: 32K		Hillsborough, FL MedEd/DSH:5.6% Medicare pop: 86K		Orange, CA MedEd/DSH:6.0% Medicare pop:242K		Bronx, NY MedEd/DSH:25.6% Medicare pop:123K	
	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change	Payment amount	Annual % change
1997	$260.46	NA	$375.32	NA	$485.65	NA	$486.70	NA	$572.69	NA	$728.24	NA
1998 (90/10)	$350.00	34.38%	$387.37	3.21 %	$489.11	0.71%	$490.42	0.76%	$572.98	0.05%	$728.24	0 %
1999 (85/15)	$367.55	5.01%	$398.61	2.9%	$499.50	2.12%	$496.40	1.22%	$578.54	0.97%	$728.24	0%
2000 (80/20) Favorable selection adjustment	$365.42	-0.58%	$409.93	2.84 %	$504.19	0.94%	$501.40	1.01%	$584.18	0.97%	$703.71	-3.37%
2001 (75/25)	$388.70	6.37%	$445.38	8.65 %	$537.79	6.66%	$534.95	6.69%	$623.14	6.67%	$717.78	2.0%
2002 (70/30)	$414.66	6.68%	$483.78	8.62 %	$573.67	6.67%	$571.22	6.78%	$665.03	6.72%	$732.14	2.0%
Percent Change 1997 - 2002	59.2 %		28.9 %		18.1%		17.4%		16.1 %		0.5 %	

NOTE: These rates are estimates, based on estimates of components of the rate setting methodology, such as the Medicare per capita growth rate. No county would receive a decrease in rates during the 5-year budget window, except in the year 2000. In 2000, almost 2/3 of counties (64 percent) would receive increases: the other counties would receive either no increase or a decrease no greater than 3.37 percent.

Chart 2


Percent Difference between County Rates and the Mean of County Rates
Under Current Law (1997)
Frequency
(# counties)
1100
1000
900
800
700
600
500
400
300
200
100
0
-50% to -40%
-40% to -30%
-30% to -20%
-20% to -10%
-10% to 0%
0% to 10%
10% to 20%
20% to 30%
30% to 40%
40% to 50%
50% to 60%
60% to 70%
70% to 80%
80% and over
Under the Administration's Bill for 2002
Frequency
(# counties)
1100
1000
900
800
700
600
500
400
300
200
100
0
-50% to -40%
-40% to -30%
-30% to -20%
-20% to -10%
-10% to 0%
0% to 10%
10% to 20%
20% to 30%
30% to 40%
40% to 50%
50% to 60%
60% to 70%
70% to 80%
80% and over
Source: HCFA Office of the Actuary, 1997
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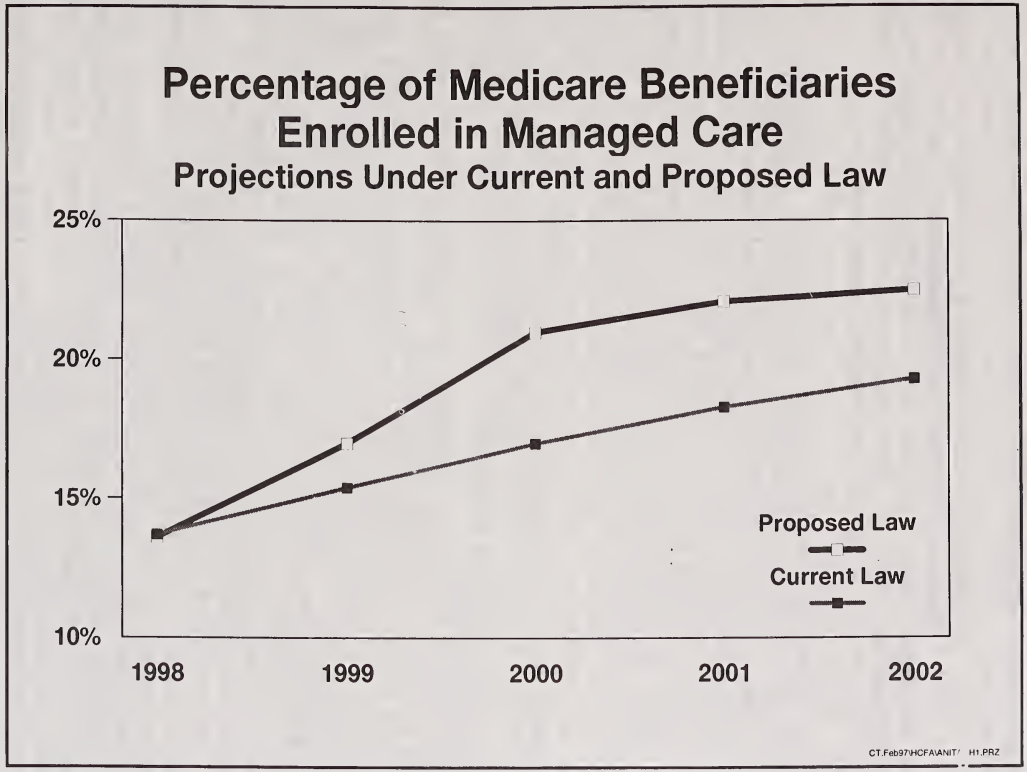
Percentage of Medicare Beneficiaries Enrolled in Managed Care
Projections Under Current and Proposed Law
25%
20%
15%
10%
1998
1999
2000
2001
2002
Proposed Law
Current Law
CT.Feb97\HCFA\ANIT/ H1.PRZ

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Mr. BILIRAKIS. Thank you. Hopefully what has not already been communicated by you will be done so by virtue of the questions that we ask.

Well, sir, as I indicated in my opening statement, something like 12 percent I guess of Medicare beneficiaries are enrolled in Medicare managed care. I do not know, it seems like when we first started on this subject 2 years ago we talked in terms of something like 9 percent, but I guess the increases have been——

Mr. FRIED. Healthy.

Mr. BILIRAKIS. Healthy, to the point now we are at 12 percent.

And current trends from CBO, from PPRC, and PROPAC seem to suggest that to one degree or another the future of Medicare will be in managed care. And I believe that this is a sentiment that is shared by the administration. And I guess we have to ask ourselves the question, and I know you did your best to sort of try to respond to this in your statement, but, you know, one-third of the President's Medicare savings come from reductions in payments to HMOs. So, you know, we have to ask ourselves the question, is not the administration really undermining the potential of Medicare managed care by tightening up on the AAPCC rate itself. Do we not really, I think, should we not logically expect that these proposed cuts will have some effect, maybe a slowdown in enrollment of Medicare HMOs?

Mr. FRIED. It is a fair question, Mr. Chairman, and I hope I can give you comfort that the answer is no.

First of all, specifically to the last question, both HCFA's actuaries and the Congressional Budget Office have analyzed our proposal. The HCFA actuary found that, given the interactive effect of our proposal, the addition of new methods of delivering health care, PSN's and PPO's, and the ability now to grow managed care in parts of the country where it was simply inhospitable financially before, we expect to see an acceleration in the enrollment.

CBO projected that there would be no slowdown in the current trend in their testimony before the Ways and Means Committee. So the actuaries, at least, think we are on solid ground.

The point about the significant budgetary reductions in the President's proposal is worthy of comment. Clearly we feel strongly that we are overpaying. I think no one would want to have plans overpaid. That is part of our reduction.

As I have mentioned, the reduction of the GME and DSH moneys from the managed care budget is actually made up in paying those funds directly to the hospitals on behalf of managed care beneficiaries, and so in a real sense there is no loss of the payment. GME and DSH payments are more certain to get to the eligible organizations where Congress intended them to go.

The third and frankly the largest projected savings result from the proposal to reduce payments to the hospital, physician, and other sides of our fee-for-service business. Because these are related to our payment methodology for managed care, the savings on the fee-for-service side are also reflected on the managed care side.

Mr. BILIRAKIS. Let me just to sort of finish up my line of questioning, I am a PSN, so that I am just really so very, personally very pleased that the administration has placed some emphasis on them. And I feel that they are important not only from the stand-

point of cost but maybe even more so from the standpoint of quality. It would be—you know, we still get an awful lot of complaints from our constituents about managed care, HMOs, in terms of quality or, as they see it, lack of quality, and I think PSN's can be—the competition can be really great in that regard.

Now I guess I do not have—I am not clear in my mind how you feel that the PSN's will be helpful in this regard from the standpoint of costs. You know, you have indicated that one of the reasons why you feel that there will not be a reduction in——

Mr. FRIED. Well, I am not sure I answered it quite that way. I think simply the development of greater competition in the managed care market is beneficial not just on the side of quality, that is obviously an important consideration, but on the cost side as well. These organizations are going to have to demonstrate their value, and there is a constraining effect I would expect to see.

Mr. BILIRAKIS. But the reduction in AAPCC will also involve a reduction to—insofar as PSN managed care is concerned. They are AAPCC; right?

Mr. FRIED. Well, everyone will——

Mr. BILIRAKIS. And so how will that be helpful in terms of continuing this increase in managed care?

Mr. FRIED. PSN's in a particular county will enjoy the same payment that an HMO will in that particular county. I know, for instance, in Mr. Ganske's area, in Iowa, our payments are quite low. I have had a number of direct conversations with PSN's in Des Moines and other parts of the State that were very eager to get into the business, and clearly could not under our current payment methodology. These new payment methodologies, I am quite optimistic, are going to be able to make this a viable proposition for those organizations.

Mr. BILIRAKIS. Well, when we get to Dr. Ganske possibly we can hear his response to my concern in that regard.

Well, let us just go on to our ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

First, the administration's budget proposal carves out disproportionate share and graduate medical education financing from the payment rate. I assume that managed care companies will tell us that they have financed a number of additional benefits, whether it is prescription drugs or eyeglasses or jazzercise classes with the HMO in California with this extra money.

Describe the policy rationale, if you would, for taking these two payments out of the payment rate, how they currently work under fee-for-service, so we understand that a bit better, and what impact this carve-out will have on teaching hospitals and on public facilities that treat a large number of uninsured, I guess the Bronx and in other places.

Mr. FRIED. Well, both the medical education moneys and the disproportionate-share moneys are adjustments that are paid specifically to teaching institutions, hospitals and others that run accredited residency programs—including in some instances managed care—and also to hospitals that are bearing a disproportionate share of the care provided to uninsured and low-income individuals.

Because of the structure of the AAPCC, which reflects the level of payment on the fee-for-service side, there is captured in the AAPCC payment what would have been the medical education and DSH payment on the fee-for-service side if there had been one. This amount varies from county to county.

The policy rationale for all of this is that those moneys ought properly to be paid through the plans to either academic medical organizations or DSH hospitals. There is a growing body of concern that, in at least some instances, those moneys are not finding their way through to those institutions.

The proposal is to separate the GME and DSH portion of the AAPCC out of the AAPCC payment or the adjusted payment that we will have in the future. The plan would still receive the regular payment for its beneficiaries, but the payment to the academic medical organization or to the DSH institution, instead of being paid to the plan and through the AAPCC, would be paid by HCFA directly to the academic organization or DSH hospital at the point of discharge of a Medicare beneficiary enrolled in a managed care plan.

Does that help?

Mr. BROWN. Yes.

You said in some cases the moneys do not find—the AAPCC moneys—do not find their way to these hospitals, the disproportionate-share hospitals, the teaching hospitals. How do they find—sometimes find their way? Do in some cases HMOs just simply turn the money over or—there is no legal requirement for that, I would guess. Correct? How does that happen?

Mr. FRIED. There is certainly I think an intention in law that the GME and IME and DSH funds be paid to eligible organizations and not kept by the managed care organization unless it itself has a residency program perhaps.

Let me answer it this way if I could, Mr. Brown. In my estimation this carve-out should not harm any managed care organization. They will still be paid the rate that is appropriate for their county without the GME, IME, or DSH payment. Those moneys will be available to be paid for care rendered to their beneficiaries in appropriate organizations. Managed care plans may not have the money available in their accounts during this time, but I do not know that that is what is appropriate.

Mr. BROWN. The AAPCC money technically does not belong to the HMO, it belongs to the hospital, to the teaching hospital or the disproportionate-share hospital.

Mr. FRIED. I do not know that I would say it that way, but I would say that my understanding of the intent of Congress is that the GME, IME, and DSH moneys were to be paid to these institutions.

Mr. BROWN. Let me ask a question that is a bit different.

You have a chart, the third chart you have in your hand now——

Mr. FRIED. Yes.

Mr. BROWN. Which is not up there—and this question will be brief, Mr. Chairman—it is under proposed law versus current law, and the percentage of Medicare beneficiaries enrolled in managed care. Under the proposed law in 2002 the number looks to be about 17 or 18 percent of beneficiaries will be enrolled in HMOs. Under

your plan and the President's plan, it would be 23 or 24 percent it looks like by 2002.

Understanding that as you bring the community in Nebraska up, there will be a plan that is attractive enough for them to join the HMO, do you—is there any downward pressure on those in Orange County or those in the Bronx that they will—that the trend toward enrolling in HMOs will slow or will be arrested or turn downward in those cases, or is it only an upward push from this shift of reimbursement?

Mr. FRIED. I do not know that we have a county-by-county projection, but let me walk through what the actuaries shared with me about how they came to this. Certainly there will be some downward pressure in the most highly paid counties, but those are also counties where there is typically significant competition. And what we have seen in any number of markets in the country now is that as the number of plans in a particular market increases, the benefits available to beneficiaries become more generous and the premiums charged to beneficiaries move down to zero, frankly, almost irrespective of what the AAPCC payment is.

There is a limit to that obviously. The St. Paul, Minnesota area is a fairly low-paid part of the country where there is healthy competition, but the payment is not sufficient to support zero premiums or high benefits. But in other very moderately paid markets, not just the high end but even at the middle, it is competition that leads to zero premium and high benefits.

One of the other realities of this is that in these highly paid counties, which are often areas with a large managed care enrollment and large numbers of Medicare beneficiaries, you have to squeeze them down proportionately less than one might think in order to raise the lower-paid counties where there are not as many Medicare beneficiaries. And so you can raise the lower side more with some pressure at the top.

But then the final point is the one you made. By providing a better floor for payment, managed care becomes a viable business proposition. With the ability to build a network and run it without losing money, managed care becomes a real option.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman. I am going to reclaim the time I did not use in my opening statement now.

I am clearly missing something here, because—and I need you to help me with this. If the AAPCC is an accurate reflection of what it costs to provide health care in a particular county, and HCFA is willing to pay 95 percent of that to a managed care company to provide that care, and if we assume that the difference in the high AAPCC's and the low AAPCC's has to do with what it actually costs to buy health care there, and utilization—and utilization is affected by things like distance to health care facilities, culture——

Mr. FRIED. Yes.

Mr. GREENWOOD. And health—then why do we keep insisting that just because the AAPCC is low, they cannot make money there? It is low because it does not—because it costs less there.

Mr. FRIED. Sure.

Mr. GREENWOOD. I mean, if it were automobiles that cost $1,000 on average to service in a particular county, and the service station has a choice, you can bide your time and let the people come in and pay you for, you know, a month to month lube job or what have you, or we give you a thousand bucks and service all of the cars, some guys are going to—sometimes you get lucky, sometimes you will not. It does not seem to matter to me whether that thousand dollars is an accurate number, does not seem to matter to me whether it is a low number or a high number, if it is accurate. So, why do we need to jimmy around with these things to begin with?

Mr. FRIED. There is some calculus, that I certainly am not capable of doing, that relates the payment level in a particular county to the population density of that county. Notwithstanding Minnesota-St. Paul fairly low-paid area, there is a substantial population there. It is a dense county. The economies of scale permit these organizations, and the culture in that community permits managed care organizations to make a go of it at the payment rate. But at least in my mind, there are other parts of the country with a more disperse population, where the payment rates simply do not support building the kind of network that our standards obligate managed care organizations to build in order to meet our contracting requirements. The payment rates in those areas do not support the cost of doing business.

Mr. GREENWOOD. So if I understand your testimony just now, you do not know why, but you believe it.

Mr. FRIED. Well, I think——

Mr. GREENWOOD. Somebody told you this is the way it works.

Mr. FRIED. I think we can see it in the behavior of health care systems across the country. I think that where you have a sparse population and insufficient resources provided to build a network, even one using telemedicine technology, the resources available would not permit an organization to be viable.

Mr. GREENWOOD. Okay, sir. I do not mean to be flip, but what you are saying is there is a calculation here that you do not—you cannot recite that demonstrates the dissatisfaction of somebody at HCFA that this is the way the world is working out there, as opposed to simply the observation that we are not finding much managed care in these low-AAPCC areas.

Mr. FRIED. I think perhaps the way to answer the question, Mr. Greenwood, is notwithstanding our proposing to go to a $350 floor, there will be counties in the country that will not have the density of population that will support the building of a network of organizations or physicians or hospitals to allow managed care to really work in that kind of a community.

Mr. GREENWOOD. I am sure Mr. Ganske will explain this to me at some point, but if there is some information in HCFA's hands, even if it is the information that you do not quite grasp, I would appreciate it if you would send it to me.

[The information follows:]

The current AAPCC is an accurate reflection of what Medicare is actually paying on average for a Medicare beneficiary in fee-for-service in a particular county. It is a function of both the payment and utilization levels in a county. Given that it is, however, simply the aggregation of fee-for-service payments, it does not necessarily represent the "costs" that a managed care entity would face if it provided care in that county:

- With respect to payment, the payment levels for individual services included in the AAPCC are based on administered prices from Medicare's fee schedules. Managed care plans may have to pay more or less to obtain the same services. The number of providers in a geographic area would clearly impact on the costs to a managed care plan of obtaining services. Managed care plans are in a stronger negotiating position if there is an oversupply of providers in a county.
- With respect to utilization, the AAPCC reflects actual utilization of services under a system where, on the one hand, providers are paid more for doing more and, on the other hand, scarcity of physicians or the geographic isolation of a beneficiary may result in inappropriately low utilization. In either case, the utilization levels reflected in the AAPCC may be above or below the level that would be optimal from the perspective of maintaining a beneficiary's health.

The current difference between the highest and lowest county rate is 250 percent. We believe that this difference is significantly greater than difference than can be justified based on geographic differences in costs or patterns of utilization. By 2002, under the President's proposal the difference between the highest and lowest paid counties would be reduced to 100 percent.

Mr. GREENWOOD. And I would love to yield to the gentleman, but I have a couple questions here, and if I have time, I will.

I want to talk about the other end of the scale, which is near where I live. I am from Bucks County, Pennsylvania. My mother and father get their Medicare through managed care, and under the President's proposal here, HCFA's proposal, what is going to happen is this $575—that is per month I guess, right?—per month fee that they are getting now—the managed care company is getting—gets frozen for 2 years, and it drops and it slowly builds up, so over the course of, I guess, between now and 2002 it goes from $575 to $641. My mom and dad get prescription drugs and it is the other inducements that drove them there.

I would like to know what your expectation is, what will happen to my mother and father here with this? Is it your expectation that (a) there is so much fat in the system that they will enjoy the same benefits in the year 2002 that they are now, or (b) that they are going to lose prescription drugs and maybe other benefits?

Mr. FRIED. I am hesitant to speak with precision about Bucks County, because I do not know——

Mr. GREENWOOD. I am obviously using that as an example; just in general.

Mr. FRIED. In general. Sure. Sure. What we know from our own actuaries and from CBO's projections is that we are going to see enrollment continue to grow. My expectation is that in many parts of the country, particularly a county such as this where managed care plans receive an above-average payment, we are going to see increased competition, not only from existing competitors in the managed care world, but from PSN's and PPO's. In my experience, watching this develop in a number of markets around the country, competition results in superior benefits and reduced premiums in a way that I think will be very attractive to many Medicare beneficiaries.

Mr. GREENWOOD. You are not predicting reductions in benefits. You think that this is going to be able——

Mr. FRIED. I would hate to say that in every market, Mr. Greenwood, but I think overall there is going to be a favorable outcome for beneficiaries.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. Fried, I think Mr. Greenwood raised an interesting point. If we are paying based on the cost of medical care in the area, you are going to change that link when you put in floors and ceilings. And you are making other changes, as well.

Mr. FRIED. Floors, not ceilings. Yes.

Mr. WAXMAN. Floors, but no ceilings. But you are making other changes as well at the same time.

Mr. FRIED. Yes.

Mr. WAXMAN. You are going to have a carve-out of DSH and medical education costs. Now in some areas that carve-out can be a very sizable part of the current HMO payment, some places approaching 20 percent, I am told. So when you consider the effect of a carve-out and you look at variations in payments between different areas in addition to this carve-out policy, there are going to be some extremely large impacts in some areas—for example, urban areas, like the one I represent.

Mr. FRIED. Indeed.

Mr. WAXMAN. Have you thought about how you are going to protect against a massive reduction to the HMOs in some of these urban areas?

Mr. FRIED. I guess the question is, Mr. Waxman, is the money available for beneficiaries. That may be another way to ask the same question. Notwithstanding the money being carved out of the payment to plans with regard to the GME and DSH payments, those moneys remain available to pay for care for Medicare beneficiaries in managed care plans.

I would expect that in your part of the country and others, the HMOs will enter into some very interesting conversations with the academic medical institutions and others to take into account the fact that we are going to be paying these institutions directly on behalf of the managed care beneficiary.

I think frankly we have heard a great deal of wailing and gnashing of teeth from plans about what the implications of this are. But I can tell you that my sense, in talking with a number of people in the industry, is that once they have seen these numbers, understand the interactive effect, and recognize that there will have to be some adjustments made in business practice, is that we are going to see any significant departure of HMOs from L.A. or Orange County or any other part of the country.

Mr. WAXMAN. And you do not want to see a disincentive for the HMOs to use these kinds of institutions.

Mr. FRIED. Absolutely.

Mr. WAXMAN. But I want to touch on a couple of other points in the few minutes I have left.

Last Congress we debated some Republican proposals that many of us feared, because they would permit extra billing for Medicare beneficiaries who enroll in some of these private plan options, would be very negative for a lot of people. I hope as a result of that debate we have pretty universal agreement that we do not want to undermine the protections of the current law in any way. The administration is attempting to open up managed care options a bit, providing the PPO option and recognizing provider-sponsored organizations.

I think there is a lot of promise in doing that. But let me just for the record get assurance from you that you do not plan to have any changes in the balance-billing protections, that they are going to stay in place and they are going to continue to be enforceable.

Mr. FRIED. All the beneficiary protections that exist in managed care programs now will be applicable to new organizations that we do business with.

Mr. WAXMAN. Including the balance billing?

Mr. FRIED. Yes, sir.

Mr. WAXMAN. I commend you for that. I also commend you for the fact that the administration is putting a high priority on providing protection for beneficiaries enrolled in managed care in the Medigap area, because a lot of people in these HMOs may want to go back to fee-for-service and a Medigap policy. Unless they have these protections, they are going to have trouble because of preexisting-condition limitations or very high premiums because of their age. I think assuring them that Medigap coverage will be there and that the premium will be community rated will give many the assurance that they can try out managed care without the kind of risks they face now.

I know some in the industry are arguing that these protections will come at the cost of large increases in Medigap premiums, and I am sure you have thought about this. Could you give us some sense about this?

Mr. FRIED. I appreciate your giving me the opportunity to answer the question, Mr. Waxman.

We know that there are five States now that have instituted the kinds of protections that we are proposing to institute nationally, which is to say community rating in the pricing of Medigap policies and no preexisting-condition exclusions. Maine, Massachusetts, Connecticut, New York—I guess that is four States—have such provisions in place now, and we have seen no disruption of the Medigap industry in those States.

I think we share your view on this. If we are going to make choice meaningful, then it has to be unencumbered in both directions. If beneficiaries find for whatever reason that managed care is not to their liking, they should not face the hurdle of a preexisting-condition exclusion or out-of-reach costs because of age rating in buying Medigap coverage.

Mr. WAXMAN. Thank you.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Waxman.

Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

Gee, there is so much to think about asking here. Will we have a second round of questions with Mr. Fried or not, Mr. Chairman?

Mr. BILIRAKIS. I doubt that, because we have another panel yet.

Mr. FRIED. Mr. Chairman, let me make it clear, I am happy to spend time with Dr. Ganske or any other member.

Mr. BILIRAKIS. Well, and questions also can be submitted.

Mr. GANSKE. Well, let me briefly respond to you.

Mr. WAXMAN. Mr. Chairman, let me ask unanimous consent at least his 5 minutes start now, because——

How much he will have available later?

Mr. BILIRAKIS. Without objection.

Mr. GANSKE. Thank you.

Mr. Fried, I think you alluded to the basic reason why the administration is proposing a change in the AAPCC in the first part of your testimony, and that was that there are certain areas in the country where the funding formula has been so rich that it may have been subsidizing the non-Medicare portion of that business. Is that not correct?

Mr. FRIED. I do not know that I would characterize it as subsidization, but it certainly——

Mr. GANSKE. Let us say that it has been very rich because you had plans, for instance in Pennsylvania, where Mr. Greenwood's parents are living, where beneficiaries in managed care plans can get prescription drugs or membership in a health fitness club or other benefits. And I think what the administration is aiming at and what Congress aimed at last time was not necessarily an issue of savings in this area, but an issue of fairness, and to really promote, as you said, choice, because in my area there is no managed care, there is no opportunity for the constituents in my area, who pay the same Medicare tax, to receive free prescription drugs. Is that not correct?

Mr. FRIED. It is a fundamental reality, Mr. Ganske, you are quite right.

Mr. GANSKE. So, in your words, it is a fundamental reality that there exists an inequality in the system today in benefits around the country, and that what the administration is proposing is to try to equalize that across the country as a matter of fairness and equity.

Mr. FRIED. I think our fundamental obligations are to provide a system for our beneficiaries that it is as fair and equitable as possible. We are certainly trying to move in that direction with this proposal.

Mr. GANSKE. Well, let me just talk briefly about a difference between where we were in 1995 and where you are now in terms of how you are attempting to achieve that. You basically have adopted a floor, like we had. Now what the congressional proposal was before was basically to allow continued growth at a certain percent for those that already have very high reimbursements, and a doubling of that growth for those at the bottom, and then a graduated change across. And we did not get into the GME/DSH because we handled that in a little different way. We basically set up a trust fund and handled medical education basically in a general-revenue way because it benefits everybody in the populace, not just the elderly. And that's sort of how we did that.

But when I look at your plan to cut 5 percent across the board in 2000, if we look at say the Bronx, what we have is in 1999 a payment of $723, and then in the year 2000 it goes down to $703. A former director of the Congressional Budget Office has testified that that type of drop is likely to cause some significant political problems when the year 2000 comes around, and in fact I believe he testified that he doubted that it would ever come about.

So I would like to work with you on a more gradual way to achieve that rather than that notch——

Mr. FRIED. Yes.

Mr. GANSKE. Which reminds me an awful lot of other notches that Congress has dealt with—as a way to more realistically achieve something and to start it a little faster. That would be one area that I think we need to look at.

Mr. FRIED. If I could respond, I looked forward to working with you in any regard.

I think the point to realize as one looks at the chart is that the carved-out funds are not reflected on the chart. The money that we have taken out of the managed care payment, the GME/IME/DSH money, remains available. It actually comes on top of these funds in terms of the payment to appropriate institutions, on behalf of the managed care beneficiary. It does not get paid to the plan, so it is not reflected on the chart. So I think as we have looked at it while the plan payment is actually zero, there is zero increase in the first few years, and then a negative in the third. In terms of the payment on behalf of the beneficiary it is actually not going to create the kind of political concern that one might fear.

The earlier comment you made about looking at the broader challenge of graduate medical education, recognizing that there is a broader societal question there, is one that the administration is also interested in. I think we would look forward to working with Congress, as we have in the past, to find a public policy strategy that gets to that important question as well.

Having taken the money out of the AAPCC and having it in a pot may facilitate further movement toward a general trust fund.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

If I may, a few questions.

Has HCFA ever considered contracting on a statewide basis, so managed care companies would receive a statewide payment for each individual enrolled. The managed care company would then contract with providers across a State, and in order to provide a managed care, the network would have to be statewide, and by paying a statewide rate, the companies and providers could then negotiate their local rates.

Rather than set the reimbursement rate or tie the reimbursement rate to some arbitrary economic indicators, would it make more sense to allow managed care organizations and providers to determine the rate in the market?

Mr. FRIED. The short answer, Mr. Stupak, is there has been no specific analysis done of the question you have just asked. As we have looked at the letter from your constituent and thought in a most preliminary way about it, some of our actuaries have expressed a concern that the result of such a strategy might have an opposite effect than the one that is being sought.

Mr. STUPAK. Opposite in what way?

Mr. FRIED. In the sense that managed care organizations might be motivated to migrate to lower-cost rural areas, keeping the statewide payment rate, leaving the higher-cost urban areas without managed care plans, or with substantially lower premiums.

Mr. STUPAK. But to prevent it, if you required them to offer it statewide, then they really could not do any cherry picking in the State.

Mr. FRIED. I understand the point, and I think it's worth our exploring that and giving some thought to it.

[The response follows:]

Mr. Colburn's suggestion of requiring all managed care plan contracts to be on a statewide basis is one way of addressing the current variation in county rates within a state. As I mentioned earlier, such an approach has some significant drawbacks:

- It would create incentives for gaming under which plans could focus their marketing efforts on areas with below area costs while receiving a rate based on a statewide average.
- The statewide mandate would be a significant change in regard to our relationship with plans. Currently, plans determine the area in which they would like to market their product. The Federal government would now be taking this flexibility away and imposing a "one size fits all" requirement on plans.
- Most states contain a number of distinct markets for health care services. Requiring plans to compete in all markets within a state in order to have a contract could be a significant barrier for entry into the Medicare market, especially for new entities such as provider sponsored organizations.

Mr. STUPAK. Okay.

Mr. FRIED. In all of these things one has to be mindful of the unexpected consequences of the decisions, and we want to look at those.

Mr. STUPAK. Sure.

We just—Mr. Coburn and I have talked about it a number of times, and I think it is something worthwhile exploring. I hope you would consider that and let us know after you have had a chance to reflect upon it further.

Mr. FRIED. I would be happy to do that.

Mr. STUPAK. What your feelings are.

My other concern is, as I brought out in my testimony, that the factors do not accurately reflect the cost of providing health care, especially in rural areas. Mr. Coburn's letter made a persuasive case that the costs to practice medicine are not accurately reflected in the payment methodologies. If rural areas were to pay doctors and technicians the same amount as their urban counterparts, what is the explanation for using a wage index that does not reflect health care wages?

Mr. FRIED. Well, it is fundamentally a question for the fee-for-service side of the Medicare program, and it is part of the historical evolution of how we pay providers, specifically physicians in this instance.

I think, in the context of this hearing, one of the opportunities that is presented by creating a floor that provides some base to work from. It may be that Mr. Coburn and others in his community health center may find their way to a strategy that other FQHC's in other parts of the country have found. That is, they might create their own provider-sponsored network to become a contractor with us. At that point the question of how much they pay their physicians and providers is one that they will be able to struggle with and find a way to work in the best interests of their beneficiaries.

Mr. STUPAK. But in order to pay those providers, see, they have to pay the same as the urban areas. We get a doctor up north in the rural areas, we work them to death and they want to leave because they are on 24 hours a day, 7 days a week, 365 days a year.

Mr. FRIED. Sure.

Mr. STUPAK. So when you really take a look at medicine, I think the way the fee-for-service methodology is constructed, I think it is unfair. I think the system is flawed, and you are using that same flawed system. And, you know, this is just not me talking, this has been going on for a number of years. You started with the DRG's and everything else. Therefore, you are using a flawed system to now take that basis of that flawed system and using it for reimbursement rates in managed care. So while we are trying to promote managed care, if the basic premise is flawed, the whole system is flawed as far as we would advocate.

Mr. FRIED. I cannot argue with your point. You have really made an important point. I simply would observe that our efforts toward narrowing the range here will have a significant benefit in Charlevoix County. The increase in payment from 1997 to 2002 is going to be 32 percent. I think that will help. I understand it does not address the underlying issue.

Mr. STUPAK. We are not disputing that. In fact it may very well help in the long run in my area if this holds probably benefits more than any other part of Michigan. If there is a flaw, we should try to address it, not just——

Mr. FRIED. No argument.

Mr. STUPAK. Put some extra bucks there, you know. I would appreciate the extra bucks, but at the same time you have got to fix the underlying premise.

Thanks for your time, Mr. Fried.

Mr. FRIED. Thank you, sir.

Mr. BILIRAKIS. Thank you, Mr. Stupak.

Dr. Norwood?

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. Fried, I did not think there would be any lack of questions in terms of payment and costs and I want to refer to your testimony just a little bit, areas of beneficiary protections which I find it's unusual, I guess, for that to be on page 2, reading in your testimony, and then on 3 and 4. So if we could just visit a little bit about that.

The first sentence in your testimony on page 2 reads, "Current law provides beneficiaries enrolling in managed care plans." I presume you mean there Medicare managed care?

Mr. FRIED. Yes, sir.

Mr. NORWOOD. Okay.

"A wide variety of protections, many of which are not received by most commercial enrollees." Then you list the protections in law on that page.

When you say "current law," do you mean law that has been actually written into the language by Congress or are you referring to rule and regulation from HCFA that has then gradually become law?

Mr. FRIED. It is a mix of both, Dr. Norwood. There are some provisions that are clearly articulated by law. In other instances, the Congress has given the Secretary some fairly broad discretion that we have been pursuing. For instance, we are permitted to require managed care organizations to collect and report any data that we feel is necessary to measure quality, and it is on that basis that I directed all of our Medicare managed care plans to collect and re-

port HEDIS 3.0 data this year and to participate in the survey of their beneficiaries so that we can gauge satisfaction, access, and quality from a patient perspective.

Mr. NORWOOD. I notice in the next 2 pages there are additional protections that you feel that you should promote on behalf of Medicare patients. Why is it that you feel you need so many protections in Medicare managed care?

Mr. FRIED. Yes, sir.

I think there are several things that we can talk about. One of the first bullets there, improving the appeals and grievance procedures——

Mr. NORWOOD. In general, if you please. The big picture.

Mr. FRIED. Okay. Some of what we do by way of protection for Medicare managed care beneficiaries was just picked up from our fee-for-service practices and, clearly, in managed care, we have a different system of payment with different incentives and different consequences. I think that, as we are becoming more sophisticated as a purchaser, it is important that we think about how managed care differs from fee for service, how the incentives work and how to provide appropriate protections to both sides.

Mr. NORWOOD. I guess if you have to. But what percent of patients in this country fall under Medicare?

Mr. FRIED. Let's see, there are 36 million Medicare beneficiaries. I guess about 13 percent, 14 percent.

Mr. NORWOOD. And what percent of that now is under managed Medicare?

Mr. FRIED. Five million beneficiaries.

Mr. NORWOOD. So what you are saying is you are spending a lot of time and a lot of money to protect 5 percent of the patients in this country because that is your responsibility in Medicare?

Mr. FRIED. I understand the line of your question. Let me jump ahead if I could. We understand that the Health Care Financing Administration is the largest purchaser of health care and managed care not only nationally but in any market in the country. So we are looking for ways to use our purchasing power to influence health plans, and health system behavior for both our current beneficiaries and our future beneficiaries.

Mr. NORWOOD. Well, maybe, the growth may go to 10 percent but, nevertheless, you are working hard every day to protect patients going into this new thing we are calling managed care and you are working hard for either 5 or 10 percent of the population.

Mr. FRIED. I think I would differ with you only in saying that I personally expect the work we do to have an impact beyond the Medicare program, and I think the physician incentive regulation is a good example of that. My personal expectation is that many States will pick up our physician incentive regulation and apply it in State law.

Mr. NORWOOD. Right there, when States pick that up, how many patients are they going to cover then with these protections.

Mr. FRIED. Well, within their Medicaid program, there are another 36 million beneficiaries.

Mr. NORWOOD. No, no, I am not talking about within their Medicaid program. I am talking about in general in their State. I am

trying to see how we are going to protect 100 percent, not 10 percent.

In my State of Georgia, when we get the State to pass your good ideas we then start picking up maybe 30 percent of the people in our State because 70 percent are in self-insured plans and are under ERISA and they have no protections from anybody.

Mr. FRIED. I think the answer, Dr. Norwood, is that if it is the desire of the Congress for these sorts of protections to have the force of law for all consumers in the country, then that will require legislation that——

Mr. NORWOOD. Are managed care plans saying, no, to you, I don't to do any Medicare patients because you are putting all these protections in there, heck with you?

Are they——

Mr. FRIED. I have not heard that.

Mr. NORWOOD. Really?

Mr. FRIED. Nobody has left.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentlelady from California, Ms. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman.

I am interested to know what reaction you had from insurance companies to HCFA's requirements regarding financial incentives. What I have picked up from constituents in my district, is that they were very much opposed to such disclosures and so I think it is more of a curiosity question but, obviously, I think it is an important one.

Mr. FRIED. Frankly, I am extremely proud of how we developed the physician incentive regulation. We spent a long time talking to consumers, the medical community, health plans, working hard to meet our policy obligations in a way that respected the realities of the practice of medicine and managed care medicine and to provide the kinds of protections that beneficiaries need.

There was a great deal of anxiety and there were frank discussions during that process but at the end, when the regulation was finally issued and became effective, I think we saw very little concern. I think we really worked it out.

Just by way of update, it is still very early in the implementation process but I should say I have been impressed at how responsive the plans have been in meeting their obligations.

Ms. ESHOO. Thank you.

And I noticed that one of the enhanced protections for women is the assurance that all medically necessary care will be given to them. To those having mastectomies, does this include reconstructive surgery?

Mr. FRIED. The question there is a more complicated one than——

Ms. ESHOO. It is a more complicated question or a more complicated answer?

Mr. FRIED. Well, let me say it this way. The fundamental question in any provision of care is whether the care provided is medically necessary in the estimation of the physician and the physician's patient.

Ms. ESHOO. That is what the insurance companies say, all right, and they deem that as being cosmetic. That is why I am asking the question.

Mr. FRIED. One of the protections that is peculiar to the Medicare program is a mechanism for appeal. Should a managed care organization determine in their first decision that the care is not medically necessary, a patient can appeal that initial decision for a second look by an uninvolved professional in the plan and, finally, to HCFA.

Ms. ESHOO. Have we set forth standards? Has the administration set forth standards relative to Medicare/managed care? Is there any thought to including this as a standard? Because if it is simply a replication or a duplication of what insurers do, this Congress, one of the most conservative congresses in the history of the country in the 104th Congress, we got into defined benefits. You know, so when you set these standards is there anything that you set up that recognizes that mastectomies and what follows is not considered cosmetic, allowing coverage for reconstructive surgery. That is my question.

Mr. FRIED. Part of my hesitation was, frankly, that I wasn't sure whether we covered reconstructive surgery on the fee-for-service side. My colleagues advise me that we do. If we cover it on the fee-for-service side, it is also covered on the managed care side.

Ms. ESHOO. So the answer is, yes.

Mr. FRIED. Yes.

Ms. ESHOO. That is great news.

Let me complement you for the way you have at least in my view answered everyone's questions. I think you are very forthright and comfortable and avoid being territorial even though you have an important area to protect and I especially appreciate it. I think it is refreshing.

Mr. FRIED. Thank you very much.

Ms. ESHOO. Thank you.

I yield back, Mr. Chairman.

Mr. BILIRAKIS. Thank you.

Mr. Whitfield.

Mr. WHITFIELD. Thank you very much.

You know, whenever I travel around my district, and I am sure it is similar in other districts, whether you talk to doctors, hospital administrators, patients, whoever, everyone expresses frustration about the Medicare system. And then when you sit in on these hearings and you talk about the adjusted average per capita cost formula and the fact that very few people can explain how it is calculated and then you talk about the actuaries at HCFA, a few of them maybe understand and they have these feelings, I just get the feeling that this whole system is so Byzantine, so micro managed, this whole health care industry which provides an indispensable service to all of our people, but do you ever get the feeling that this is micro management at its ultimate?

Mr. FRIED. I think this is as complicated as anything mankind could devise.

Mr. WHITFIELD. And before we had the adjusted average per capita cost formula, for example, what did we use?

Mr. FRIED. Well, the AAPCC was crafted as part of the Tax Equity and Fiscal Responsibility Act of 1982. So it has been part of the landscape for 15 years now.

Mr. WHITFIELD. What did we use before that?

Mr. FRIED. It was a prepayment methodology that was not particularly sophisticated. We were trying to figure out how to do this.

Mr. WHITFIELD. You know, the thing that I find so interesting, every Congress has good intentions, every administration has good intentions and they come forth with new proposals. I mean, we came up with the diagnostic-related groups and now we have these hospitals, for example, that are under those they get certain payments for certain days for certain procedures. And now many of them are going over to sub-acute care. So they are taking people out before they are supposed to be out of the diagnostic-related group and they are being paid a flat fee for that. Then they go over to the sub-acute care and we know the cost there has increased over 300 percent in the last 3 or 4 years. And so they get the DRG payment and then they are over here getting per day $564 a day plus therapy plus nursing care plus everything else.

So it seems like every time we try to do something, disproportionate share or whatever, these innovative folks figure out ways to get around it.

Mr. FRIED. If I could just make an observation that is in some ways reflective of your comments, this is an incredibly complicated system. It is complicated because we are dealing with an awful lot of people, all of whom are different, all of whom bring different health status, different cultural issues, different values to the equation. We are dealing with an astronomical amount of money. We are dealing with a health care system where all of our values are in conflict; whether it is providing the highest quality of care, sustaining life to the utmost, or being proper stewards of our natural resources.

Part of the excitement about being a policymaker in this health care system is to have the opportunity to try to resolve the inevitable struggle between mutually conflicting values. And I think that is, in part, why health care policy is as it is.

Mr. WHITFIELD. You know, I have read a lot of these reports, a lot of the testimony and many people are suggesting that we go to some sort of competitive free market system on this health care and one suggestion I guess was made by the physicians group, and they said they have made it repeatedly, is that HCFA test some of these methods and I understand maybe in Baltimore you all tried to do one and it didn't work. What happened there?

Mr. FRIED. We are still working with the local community and Members of Congress in Baltimore to address their concerns. We have recently announced that we are going to be conducting a competitive pricing demonstration program in the Denver area, and we are currently engaged in meetings with all of the affected parties in that community. We expect to be up and running, have bids submitted, base our payments on those bids, educate those consumers and be launched on January 1, 1998.

Mr. WHITFIELD. Well, I see my time is up, so thank you.

Mr. GANSKE. I think Mr. Strickland must be next.

Mr. STRICKLAND. Thank you, Mr. Chairman, and thank you, Mr. Fried.

I concur with Ms. Eshoo's statement regarding your presentation today and I would like to just maybe back and forth in a couple of quick questions.

Conventional wisdom, it seems to me, holds that managed care is desirable because it saves money. Is that a statement that you would concur with?

Mr. FRIED. I think the incentives in the current health care system are toward cost containment, and managed care has done very well at that on the commercial side.

Mr. STRICKLAND. And has managed care saved money for the Medicare system?

Mr. FRIED. The research leads us to believe very strongly that it has not.

Mr. STRICKLAND. That it has not?

Mr. FRIED. That it has not.

Mr. STRICKLAND. There doesn't seem to be a lot of questioning that this is something that we ought to continue to encourage and pursue. Can you tell me, based on your best judgment, why we are doing this when we don't have data suggesting that it is saving us money? And I don't know that we have data suggesting that it is providing a higher quality of care for seniors.

Mr. FRIED. Let me answer both of those questions if I can. We continue to pursue managed care as an option for beneficiaries. On the savings question, we see the behavior of the commercial sector where commercial purchasers have received significant economic value by using managed care, by aligning the incentives in a way that has worked very successfully.

The Medicare program and particularly our beneficiaries are a much more challenging population to serve by virtue of their illness, the complexity of their lives, and their economic situation. Part of what makes this difficult, I think, is that we are very much in a transitionary period from the fee-for-service system to managed care and the folks who are signing up for Medicare managed care are often the young elderly who are typically healthier than the average. So that favorable selection where we are paying a capitated fee for folks who are not using health care services is the reason for it not working.

On the quality question, notwithstanding the anecdotes that one reads and is concerned about, the research is pretty significant that managed care is at least as good in terms of quality as the fee for service program. We are engaged in significant efforts to refine our performance measurement systems so that we can truly manage quality from a variety of perspectives, both in managed care and in fee for service.

Mr. STRICKLAND. And I was interested in your protections that you have listed here and I am wondering if it may be possible that Medicare has not saved, by utilizing managed care, in part, because there are protections built in for the Medicare population that others in the managed care industry may not enjoy.

Would you speak to that?

Mr. FRIED. Well, there are certainly costs attributable to some of these protections. In my estimation they are not so significant as to account for the difference that we are seeing.

Mr. STRICKLAND. Okay, and just one more reference to one of the protections, specifically the breast cancer section here. There is a statement that I find really intriguing. It says, "The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12 we sent a policy letter to all managed care plans making it clear that they may not set ceilings for in-patient hospital treatment or requirements for outpatient treatment. Similarly, we will soon be reinforcing this message in Medicare's fee-for-service sector."

And I guess the thing that bothers me about that statement is, should this not always be true, regardless of what the person's medical condition is?

Mr. FRIED. Of course.

Mr. STRICKLAND. You answered my question.

Mr. FRIED. The policy letter communicated this policy, and actually it was more of a clarification because this has been the underlying Medicare policy from the inception of the managed care program. It was written specifically with regard to the concerns that have been raised about the appropriateness or lack thereof of certain HMO mastectomy policies. But the point was made that medical necessity is always a question of what is medically necessary for the individual patient.

Mr. STRICKLAND. I just find it intriguing that it would have been necessary to send out such a statement that was focused on such a narrow medical issue, although a very important one, when that statement ought to be unnecessary, it seems to me; it should be self-evident.

Mr. FRIED. I wouldn't argue with you, sir. Yes.

Mr. STRICKLAND. Thank you, sir.

Mr. GANSKE. Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

Mr. Fried, what has changed at HCFA in the last 18 months as it relates to HCFA's vision of Medicare managed care plans?

Mr. FRIED. I don't know. I guess we are getting smarter.

Mr. BURR. Do some of the statements that you are saying today, quality is pretty good, that you are not concerned that Medicare, as a percentage of the beneficiaries enrolled in it, is going to grow? It doesn't scare HCFA near as bad as the testimony in the 104th Congress when we were talking about increasing the options to seniors? What is new today that did not exist then?

Mr. FRIED. I don't know that anything is new, really. In the 104th Congress, the administration supported PSNs and PPOs being added to the mix in much the same way that we are proposing today.

Mr. BURR. HCFA specifically testified that quality was a great concern in managed care and expansion of managed care as it related to Medicare. What has happened since then that——

Mr. FRIED. The point I was making, Mr. Burr, is that in terms of choice, I think we have been in the same position. In terms of quality, we haven't retracted at all. In fact, in the last 18 months we have taken steps to put HCFA at the forefront of purchasers in

terms of requiring managed care organizations to demonstrate by performance data and by oversight the quality of the care——

Mr. BURR. You have a higher level of confidence in the quality today than you did 18 months ago, don't you?

Mr. FRIED. I have a higher level of confidence in our ability to capture, in an empirically sound, statistically valid way, performance measures in much the same way that other sectors of the economy are doing to try to drive quality into the competitive mix in a way that it has never been.

I think, using our market force as the purchaser that we are, we can make success for the health care system not simply a matter of who does the best job of constraining costs but who does the best job of providing value. From our view, value is achieving the highest quality of care at the lowest justifiable price. That is what we are after.

Mr. BURR. Who is the most appropriate person to determine the value?

Mr. FRIED. To determine value?

Mr. BURR. Yes, sir.

Mr. FRIED. Ultimately, it is the beneficiary and our objective is to give beneficiaries very significant performance data to help them make those decisions.

Mr. BURR. You said in your mind, and I am paraphrasing so correct me if I'm wrong, if we can adopt this new payment schedule in your mind it will accelerate competition, increase benefits, increase enrollment and save money. Is that an accurate depiction?

Let me give you my home county, it's Forsyth County in North Carolina with a 1997 reimbursement rate of $388.11, a 1998 reimbursement of $388.11, a 1999 reimbursement of $388.11, a year 2000 reimbursement rate of $394.68, a 4-year increase of $6. I have two major HMOs who both offer Medicare managed care for seniors.

How will that $6 increase over a 4-year period in your opinion affect the benefit package that those companies offer those beneficiaries?

Mr. FRIED. I have not seen the data——

Mr. BURR. Will it accomplish what you said? It will increase enrollment, it will increase benefits, it will accelerate competition?

Mr. FRIED. As I began to say——

Mr. BURR. I think you are right, it will save money but I am curious about the other three.

Mr. FRIED. As I began to say, I am concerned about the numbers you just read. I am sure they are the numbers we gave you but they don't sound——

Mr. BURR. They are your numbers.

Mr. FRIED. I hear you. It doesn't sound quite right, and I would like to take a closer look. But let's accept them as being accurate. In Forsyth and other counties of that sort in North Carolina, the opportunity is going to be one of new delivery systems that may appear as a result of our now being able to contract with PSNs and PPOs to offer more competition than ever has been possible. Again, the experience that we have had is that, as more plans enter into our market, the competitive nature of that reality leads to reduced costs for beneficiaries and increased benefits.

Frankly, I think that behavior is one that I would expect to see in many parts of the country. Whether that's precisely what is going to happen in Forsyth County——

Mr. BURR. Let me ask you. A third of the administration's Medicare savings come from payments to HMOs in which only 12 percent of beneficiaries are enrolled. Now, isn't that a little bit excessive?

Mr. FRIED. Obviously, we don't think so. The funds represent three things. The largest proportion of the savings is a result of our also realizing savings on the fee-for-service side. Given the interactive nature of the fee-for-service payment and our payment to managed care, those savings are seen on the managed care side as well. That's the largest portion of the savings. There is also a significant amount of savings attributable to carving out graduate medical education DSH IME payments from managed care payments. Those moneys, while no longer paid directly to the managed care plans, remain available to pay to appropriate organizations when they serve a managed care beneficiary. While not being available to most managed care plans, they are still available for the care of that particular patient.

The one clear savings that is unassailable is that we propose to reduce payments in the year 2000 to account for the favorable selection that is fairly well documented at this point. That is a significant reality.

Mr. BURR. Without an increase in managed care——

Mr. GANSKE. The gentleman's time——

Mr. BURR. Last question, Mr. Chairman. I appreciate your indulgence.

Without a growth in managed care, can the administration hit their balanced budget numbers?

Mr. FRIED. I think the answer to the question, sir, is that we project a significant continuing growth in managed care.

Mr. BURR. But the question, without a growth can you hit your numbers?

Mr. FRIED. From where you ask the question depends on the answer you get. If we have a system where we continue to overpay managed care organizations, no we cannot get to the kind of budget objectives that we all share.

Mr. BURR. If we don't grow at the rates you project of new enrollees into managed care under Medicare, will you in fact be able to reach the budget savings that the administration needs to contribute to the balanced budget proposal on the table?

Mr. FRIED. All I can say is that based on our analysis and projections, we can achieve the President's objective to balance the budget and save the Medicare trust fund based on these proposals and the trends that we can project.

Mr. BURR. So if the reductions have an adverse effect, if they don't accelerate competition, increase benefits and increase enrollment, enrollment being the key there, then the projections will not match what the estimates are for savings?

Mr. GANSKE. Mr. Fried, the gentleman's time has expired. If you could quickly answer that, we will move on to the next.

Mr. FRIED. Again, I would simply say we have made our best estimates. We believe this is the strategy that gets us to the point we want to achieve.

Mr. GANSKE. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman.

One advantage of being last in these situations is everyone else gets to ask your question. So I will not question you at length, especially since I am a new member and not yet used to all of the acronyms or mazes that we are talking about here in Medicare.

I will tell you though, I do have a concern looking at the figures, I mean, Mr. Burr is concerned about a $6 increase. I am looking at the figures for the major county of my district. By the year 2000, it goes down from $503 to $488. I think——

Mr. FRIED. What area are you from?

Ms. DEGETTE. Denver.

Mr. FRIED. Denver.

Ms. DEGETTE. The area of your model program.

Mr. FRIED. Yes.

Ms. DEGETTE. And, you know, I am concerned about how you attract competition in that area at all, going down $12 in the next couple of years.

Mr. FRIED. My colleagues are giving me the numbers right now.

The increase over the 5-year period is about 11 percent. And so it is a modest increase. It is an increase nonetheless. Competition is healthy and vibrant in the Denver-Boulder markets, and we expect, not only based on our competitive pricing demonstration, but generally, for that to go forward. The plans seem to be doing a great job, and I think that this will continue to be the case under our proposal.

Ms. DEGETTE. I guess my only concern is while you might have an upward trend over time in a market where you have a fairly significant drop immediately, what happens is that can hurt competition. But maybe I can talk to your staff at a later date about our local——

Mr. FRIED. I would just repeat that part of what is reflected in the numbers is the taking out of the funds for graduate medical education. When you consider those as also being available to meet the needs of managed care patients, I think you would see significant resources available for that purpose.

Ms. DEGETTE. Thank you.

Mr. GANSKE. Mr. Towns.

Mr. TOWNS. Thank you very much, Mr. Chairman.

I am not sure if this has been covered. You might have even covered part of what I am going to ask you in your oral statement, although I was not here for that testimony I did read your statement.

Mr. FRIED. Yes, sir.

Mr. TOWNS. On page 10 actually at the top of the page you indicate that the Secretary could waive the 50/50 rule for plans in rural areas. What criteria will you be considering for plans in inner-city areas that are usually ignored by commercial HMOs.

Let me even be more specific. How can the committee, here, have input in that process, in the development of the criteria?

Mr. FRIED. Let me start with where we are right now. It is set by law, the 50/50 rule. There are extremely few exceptions that permit the Secretary to waiver from that requirement.

What we are proposing is a phasing-out of the 50/50 rule, specifically eliminating it entirely at the point where we have quality standards and quality measurements that produce the quality of care that the 50/50 rule has been a proxy for. But between now and then there would be opportunities to waive the 50/50 rule in the instance of organizations with demonstrated high performance who have been in the business and have done a terrific job by any number of measures. That would be one opportunity.

There has been no commercial enrollment in many parts of the rural communities. I would think, in the same way as is done where the opportunity for commercial enrollment does not exist in an inner-city community, there should be an opportunity for the Secretary to waive the 50/50 rule in certain rural communities.

Finally I should say as part of our proposal there would be general Secretarial discretion to waive the 50/50 rule, in instances when she deems it is an impediment to choice for the beneficiary, to provide the high quality of care that we know some plans can provide without having the commercial population.

Mr. TOWNS. One other question now. Are there inner-city communities where you would also consider supporting alternative managed care models?

Mr. FRIED. I think we have looked for opportunities to explore alternative managed care models in many parts of the country. In fact, we are currently rolling out what we are calling the Medicare Choices demonstration where, in a number of communities around the country with high numbers of Medicare beneficiaries but relatively low managed care penetration, we are testing different models. Among these models are preferred provider organizations and provider sponsored networks. We have really issued a very wide call for proposals from any kind of organization that had the capacity and the resources to meet the call.

So we are experimenting with a number of things. For example some of those proposals that the President has offered to allow HCFA to contract with provider hospital organizations and PPO's and other organizations. I think we are in such a dynamic market at this point that we will find new kinds of organizations evolving in the next 2 or 3 years that we cannot even describe at this point. I think it is important that HCFA and the Federal Government be open to entering into relationships with those, particularly where the fundamental questions are, 1) is the beneficiary getting the high-quality care that they are entitled to, and 2) is the Government getting the value and price that it is entitled to ask for?

Mr. TOWNS. I like that answer, the fact that you are open. I think that we need to be open as we move forward, because we want to at the same time try and make certain that we are providing quality care, at the same time we are trying to make certain that we keep the cost down, so I think that we have to be open and sort of make certain that we look at alternative programs to be able to provide the kind of services necessary.

Inasmuch as I support what would happen in rural communities, I think that the inner city also has some very unusual problems.

Mr. FRIED. Clearly.

Mr. TOWNS. So thank you very, very much.

Mr. GANSKE. Thank you, Mr. Towns.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I wanted to ask a question of Mr. Fried concerning the provider-sponsored networks, but before I get to that, I represent parts of Houston, Harris County, and I noticed on the printout like my colleague from North Carolina that, for example, Harris County is $595 until the hold harmless ends in 2000 and it goes to $575, as an urban county, and comparing it again, I am not familiar with Lorain, Ohio, or Hillsborough, Florida, but I am familiar with Harris County, Texas, Houston, Texas, and Dallas, and compare that with Dallas County, another urban county, and the difference.

Could you just tell us why that it would happen Dallas would, for example, go down less than a dollar, whereas Harris County would see a decrease of a little over $20.

Mr. FRIED. Again, Mr. Green, I do not know if you were with us at the beginning of my presentation, but we are accomplishing several things at the same time here. Part of it is to narrow the significant range that exists in really lowpaid counties and really high-paid counties. I think we accomplish that. Part of it is to address the concern that we have about our overpaying managed care organizations given the risk that they are bearing. Part of it is to be sure that teaching hospitals such as those in your community are receiving the proper payment for graduate medical education and DSH.

When those three things come together, there is an interactive effect that is reflected here. The bottom line though is that over the 5-year period where we start at $595, at the end of the 5 years we are at $636, and so we are not going down. It is a modest increase. But on top of that, of course, you would add the graduate medical education funds.

Mr. GREEN. And that is a whole separate question.

Mr. FRIED. Yes, sir.

Mr. GREEN. So I wanted to explore on that some other time on how you do it because of the medical centers in, well, Dallas and Houston and elsewhere.

Mr. FRIED. I am sure there will be a lot of interest.

Mr. GREEN. Let me go to one of the questions though that I had, that last year on the debate on Medicare—and you talked about it with my colleague from New York about the choices and some of the things that we may see in different networks, the provider-sponsored organizations and the conflict between State regulation and Federal regulation of HMOs compared to provider-sponsored organizations.

Can you describe the administration's policy on these provider-sponsored organizations and tell us what you would do to encourage more of them to form if they need that encouragement? Because I know there is—whether they need encouragement or not, I think like you said 2 years from now we may not know what may be a provider.

Mr. FRIED. Yes.

Mr. GREEN. But those provider-sponsored organizations.

Mr. FRIED. Well, specifically we would have authority to begin contracting with provider-sponsored organizations, provider-sponsored networks. We would apply generally the same standards that are currently applied in our contracting with managed care organizations. There would have to be some attention to how to apply the same standard recognizing that these are different kinds of organizations, and we may need to meet the same standard in different ways.

In terms of the relationship between State and Federal Government, the President's proposal would allow us to contract with these organizations for the first 3 years without there being a State licensure obligation. I should say, if I am not mistaken, there are about a dozen States now that are already licensing or certifying PSN's. That is a trend I expect will accelerate. I think the acceleration will absolutely take place, if the Federal Government is entering into these arrangements. So——

Mr. GREEN. The next question in these provider service networks, and you mention it again with my colleague from New York on the waiver of the 50/50 rule, they might be in a very small area, an urban area or rural area, that would not have the opportunities as a larger HMO to comply with that. And so that would be subject to the Secretary's determination?

Mr. FRIED. It would. Just a little longer comment might be appropriate. The 50/50 rule, until it is replaced by other quality measures, is an important consideration. Many of these provider-sponsored networks are not risk-bearing organizations in the sense that they are contracting with commercial purchasers, and so part of our approach is going to be to meet the 50/50 obligations through other measures than a commercial enrollment. For instance, it may be that we will want to look at the number of patients the hospital is caring for who are at risk themselves and what risk-bearing experience they have on the fee for service side. But the Secretary's discretion would be exercised as appropriate.

Mr. GREEN. If I could squeeze in one more concerning the first 3 years on the solvency issue for the provider-sponsored organizations.

Mr. FRIED. It is very important to us that the organizations we do business with have the financial resources to go through the inevitable learning curve that will be necessary. Having said that, we also know that these are different kinds of organizations than traditional insurance risk-bearing organizations. So we are not going to apply the same solvency standard. How that is met may vary a little bit, but I think we all recall that there were almost two dozen provider-sponsored organizations in the late eighties that failed, in part because they were undercapitalized. They had not figured out how to serve this very complicated patient population.

None of us want to repeat that experience, and so I think we can find a way to be sure that does not happen.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. BROWN. Mr. Chairman, could I ask unanimous consent. I have a question to submit to Mr. Fried on behalf of Mr. Dingell, if I could submit it for the record and ask Mr. Fried to answer it as quickly as possible.

[The questions and response appear at pg. 90.]

Mr. GANSKE. Without objection.

Mr. Fried, I want to thank you for being with us today. I am going to take the Chair's prerogative and ask one question before you leave.

Mr. FRIED. Sure.

Mr. GANSKE. You talked about the fact that you feel that the Medicare managed care plans have cost more than they should.

Mr. FRIED. That is what we believe the research demonstrates; yes, sir.

Mr. GANSKE. In fact I think there is some evidence that patients enrolled in Medicare cost about 60 percent of what the average Medicare recipient does, but those who disenroll from Medicare managed care cost 160 percent. In fact, we may have some testimony on that in the next panel.

My question is this. Clearly that has been adverse selection with managed care in the Medicare plan. How do you address that?

Mr. FRIED. Well, I think there are several strategies. If you remember back to the original Mathematica report, they found that as enrollment grows, regression to the mean will occur, and you will inevitably capture greater risk. I think that will happen over time. But that is going to take some time. The strategy that we are pursuing is one where we refine our payments in a way that allows us to pay an appropriate rate to the plan for the risk that they are bearing with a great deal more precision. The work that we are doing in our Choices demonstration to refine those risk-adjustment payment methodologies is very exciting. We are seeing very favorable results, and we hope to be back to the committee in 1999 with a proposal that we hope will be ready for implementation in 2001.

Mr. GANSKE. But clearly it is a problem that those who disenroll from Medicare managed care are costing more than the average Medicare recipient, which places a stress on fee for service.

Mr. FRIED. There are several things to remember. In a hearing a couple months ago before Senator Specter, PPRC released some information analysis on disenrollment trends. They found an 8-percent disenrollment rate, and Dr. Wilenski testified that of that 8 percent, 5 percent went to other managed care plans. Three percent went back to fee-for-service.

I think we need to be cautious on one hand about how we read disenrollment information; there is more there than it first appears. But obviously, to the degree that patients are leaving managed care at a point of needing greater health care, that is a concern that we would all have.

There is a variety of work being done in the Department to look at—not just in HCFA, but in the Department—to look at why this is happening, what is causing this activity to take place. Getting the rate right is one thing, but I think we need to know more from beneficiaries about why they are making these choices.

Mr. GANSKE. Thank you very much.

Mr. FRIED. A pleasure to be with you.

Mr. GREEN. Mr. Chairman, could I just ask for one last question that you could send us the information so it would not take any more time? But those 3-year standards on the PSO's, is that going to be our standards, Federal standards, or are we going to depend

on the 12 States or however many States adopt some type of standard?

Mr. FRIED. Just quickly, the standards that we applied are largely those that are already required of managed care organizations in section 1876 of the act. They are the kinds of beneficiary standards that one might expect. The differentiation might be in how the fiscal solvency standards are met. That would be an area of some difference. The standard will be the same; how the standard is met will be different. We can have a further conversation about that.

Mr. GREEN. Okay. Thank you.

Thank you, Mr. Chairman.

Mr. GANSKE. And thank you again.

Mr. FRIED. Thank you, Mr. Chairman.

Mr. GANSKE. Now we have for our second panel Dr. Jonathan Ratner, Associate Director, Health Financing Systems, GAO; Mr. Roger Taylor, Commissioner of the PPRC; and Dr. Don Young, Executive Director of the Prospective Payment Assessment Commission.

Welcome.

Mr. Young, would you like to start.

STATEMENTS OF DONALD A. YOUNG, EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION; JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCING SYSTEMS, HEALTH, EDUCATION, AND HUMAN SERVICES, GENERAL ACCOUNTING OFFICE; AND ROGER S. TAYLOR, COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. YOUNG. Thank you, Mr. Chairman, for inviting me here this afternoon. I will submit my statement for the record and very briefly summarize.

Mr. GANSKE. I think your mike may not be on.

Mr. YOUNG. Thank you, Mr. Chairman. I will submit my statement for the record and very briefly summarize some of the key points in it.

At the back of my statement are a series of charts that I would like to refer you to if you would turn to them.

As you see in chart 1 as you have heard previously, enrollment in the Medicare risk contracting plan has been growing very rapidly in recent years, and to that extent the program has been a success. As you have also heard, however, the program has been far less of a success in achieving the savings that had been envisioned for it, and one of the major reasons for that is the lack of a risk adjustment, that is the enrollees who choose managed care plans by and large are not as sick and do not require the same level of health care services.

If you turn to chart 2, we have looked at the value of the extra benefits that are offered by risk plans. Risk plans that keep their anticipated expenses below their projected costs are required to return the money to the Government or to provide extra benefits, and as you might guess, they choose to provide the extra benefits rather than returning the money. Plans however may also offer additional extra benefits that they are not required to offer. As you can see in chart 2, the value of these benefits varies widely. Now in

this chart we have adjusted the value of these benefits based on relative costs of living across areas, so a dollar in New York City of benefits in this chart is equal to a dollar of benefits in a rural area. Ten percent of plans have a dollar or less of extra benefits that are offered. Ten percent of plans have as much as $112 or more of extra benefits that they offer.

In chart 3 we have addressed a question that has been raised a number of times this morning, and that is the relative differences in payment rates across the country, but in particular the relative differences in payment rates among urban and rural areas. Here we have adjusted the payment rates again to reflect labor costs in different areas across the country, and after adjusting for differences in labor costs, you still have rates as low as $351 or less for 10 percent of plans, and as much as $568 for 10 percent of plans. The important finding of this, though, when you do adjust the rates for the costs of labor in geographic areas, there is not much difference across the board between urban and rural areas. So when you are comparing payment rates, it is very important to also look at what the relative cost of living in different areas is.

Chart 5 lays out not only the differences in the variation across counties that you have talked about, but also wide swings from year to year. These are the extremes with increases as much as 37 percent from 1 year to another, or reductions of 40 percent. And while these wide swings are not typical, and in fact in many areas represent counties that do not even have any managed care plans, in large areas with large enrollment, we see swings also that are very substantial from year to year, and swings that are hard to justify or to understand.

The Commission's recommendations for the risk contracting program are contained in the report we will be delivering to you on March 1. These include the need to break the link with fee-for-service spending as a way of updating the payment rates; adding a better risk adjuster to modify payment rates, so they better reflect enrollees' likely use of services and so they achieve the savings that were intended. We also recommend removing the special payments to teaching and disproportionate share hospitals from the capitation rates, and distributing those payments based on Medicare's enrollees' use of the appropriate facilities. We suggest that the variation in the rates across counties be narrowed, and that a minimum payment be added to the system. And finally, we recommend substantial improvements in our ability to measure plan performance and in our ability to provide Medicare enrollees with the information they need to select appropriately among managed care plans and to select between the fee-for-service system and the managed care system. And that concludes my comments.

[The prepared statement of Donald A. Young follows:]

PREPARED STATEMENT OF DONALD A. YOUNG, M.D., EXECUTIVE DIRECTOR, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION

Good morning, Mr. Chairman. I am Donald Young, M.D., Executive Director of the Prospective Payment Assessment Commission (ProPAC). I am pleased to be here today to discuss improvements to Medicare's risk contracting program. During my testimony, I will refer to several charts. These charts are appended to the end of my written testimony.

In 1985, Medicare implemented the risk contracting program. Under this program, participating health maintenance organizations (HMOs) receive a monthly

capitation payment to provide the Medicare benefit package to each beneficiary they enroll. The risk program was created to allow Medicare to enjoy some of the advantages of capitation arrangements, such as predictable spending and savings. Beneficiaries who join risk plans also benefit because many plans provide additional services and have low cost sharing requirements.

On one level, the risk program has been a success because more and more beneficiaries are choosing to receive services under these arrangements. Since 1993, enrollment has increased, on average, 32 percent each year. Today, 4.2 million beneficiaries, or 11 percent of the total Medicare population, have chosen this option for their health care coverage (see Chart 1).

The risk program has yet to be successful, however, in its goal of achieving savings for the Medicare program. Capitated managed care arrangements have the potential to restrain Medicare expenditures because they create incentives to control the number of services furnished, as well as the cost of each unit of service. These arrangements have helped to curb spending in the private sector. To date, however, the risk program has not achieved the savings that the private sector experience suggests is possible. There are several reasons for this, most notably that Medicare payments to plans do not reflect their enrollees' lower-than-average probability of using health care services. Another reason is that the capitation rates are based on the spending experience of beneficiaries in the fee-for-service program, rather than the costs that would be expected under a managed care arrangement.

In H.R. 2491, the Balanced Budget Act of 1995, the Congress passed a number of reforms to improve the payment methodology for managed care plans. The President also has proposed a number of modifications in his recent budget proposal. ProPAC agrees with the Congress and the President on the need to better adjust risk payments and to move away from fee-for-service spending as a basis for setting rates.

In our forthcoming *Report and Recommendations to the Congress,* the Commission will recommend a number of modifications that it believes are necessary to improve the risk program. We believe that, if adopted, these actions will benefit both the program and its beneficiaries. These recommendations focus on improvements in three areas: risk adjustment, payment amounts, and risk plan information. This morning, I would like to share with you the Commission's views. But first I will briefly summarize the current method for paying risk plans.

THE RISK PAYMENT METHODOLOGY

As you know, Medicare pays risk plans a monthly payment for each Medicare enrollee to cover the program's share of costs for Medicare-covered services. This rate is based on 95 percent of projected fee-for-service Medicare program payments (the adjusted average per capita cost or AAPCC) in the county in which the enrollee resides. Separate rates are calculated for aged and disabled beneficiaries and for those who are eligible for Medicare because they have end-stage renal disease. The rates are adjusted by five factors to account for variations in enrollees' health care needs. They are the enrollee's age, sex, Medicaid status, institutionalized status, and whether the person has employer-based coverage. As I will discuss in a moment, these adjustments are not adequate to reflect enrollee spending patterns.

The Medicare program recognizes that risk plans are likely to keep their costs below their payments. While plans are permitted to return to the program any payments that exceed their projected costs, they also may use them to provide extra benefits to risk enrollees. Not surprisingly, most plans choose to offer extra benefits in the form of additional services, lower cost-sharing, or coverage of services from out-of- network providers. To further attract Medicare beneficiaries, plans may include even more benefits than they are required to provide.

Almost every risk plan provides some type of extra benefits. In 1996, the vast majority of plans covered routine physicals and eye exams. Half of plans offered some type of pharmaceutical benefit and two-thirds charged no premium for their basic package. A ProPAC analysis estimated that in 1995, the average risk plan provided each enrollee with $43 in extra benefits each month. The amount of extra benefits varied tremendously across the country, however, even after adjusting them to reflect differences in local price levels (see Chart 2). In 1995, a tenth of plans offered extra benefits valued at over $100 per enrollee per month while another 10 percent offered less than $1. As I will describe later in my testimony, the level of extra benefits that risk plans provide is associated with the payment rates in the areas the plans serve. The variation in the value of extra benefits suggests that fee-for-service spending patterns are not good predictors of the costs plans might be expected to incur.

IMPROVING RISK PAYMENTS

Mr. Chairman, as both the Congress and Administration recognize, if managed care is to be a viable option under Medicare, the risk program must be modified. First, the program needs better risk adjustment methods. Second, Medicare must revise the risk payment methodology. Immediate changes would begin to break the link to fee-for-service spending and reduce the variation in payment rates across areas. Over the longer term, Medicare should consider new ways of setting risk payment rates. I would like to briefly address each of these issues.

The Risk Adjustment Method

In concept, the risk program should generate savings for Medicare because the payment rate is 5 percent less than the fee-for-service spending that would be expected for each beneficiary in an area. Instead, however, research has shown that Medicare payments for current risk enrollees are, on average, an estimated 5 to 7 percent greater than if these beneficiaries had remained in the fee-for-service option. Thus, Medicare is losing, rather than saving, money on the risk program.

These overpayments would be reduced, and spending more appropriately distributed, if payments for enrollees were adjusted to account for their likely use of services. An adequate risk adjustment method would do this. It would reduce risk plan payments relative to fee-for-service spending to reflect the healthier population of risk plans. Further, it would increase payments to plans that serve sicker beneficiaries and reduce them to plans that have healthier enrollees.

Researchers have been evaluating methods that could be used to better target risk payments. Two have been studied. One uses diagnosis information that accounts for prior health service use. The other is based on enrollee reports of their health and functional status, and past and present health conditions. While a risk adjustment method could be designed that would draw on both types of information, diagnosis information alone measures risk about as well as using both methods together. An outlier policy to address unusually costly enrollees would further improve payments to risk plans.

An improved risk adjustment system would reduce overall risk plan payments as well as redistribute funds across plans and areas. Therefore, it may be appropriate to phase in a new system over time. Mr. Chairman, we know, however, that even the best available risk adjustment method will not fully offset efforts by plans that seek out healthier beneficiaries. Therefore, research needs to continue to seek further improvements in risk adjustment methods. This would help to ensure that Medicare payments to risk plans reflect the health care needs of their enrollees. In the meantime, a partial capitation method should be investigated as a means to reduce the effects of risk selection. This approach would pay plans partially on the basis of their enrollees' utilization, which would be lower for plans that had healthier members.

Risk Plan Base Payments

Another fundamental problem with the risk program is its reliance on fee-for-service spending to set risk payment rates. This approach has resulted in wide variations in risk payment rates. This year, for example, risk plan payments are based on rates that vary by as much as $500 per member per month depending upon the county they serve. Even after adjusting for differences in local input prices, per person payment rates can vary by as much as $200 per month across both urban and rural areas (see Chart 3).

In addition, a plan offering services in neighboring counties may receive very different risk payments for enrollees living in those counties. For example, in the Washington, DC area, the 1997 monthly per person rates range from $401 in Fairfax county to $602 in Prince George's county—a 50 percent difference (see Chart 4).

The current degree of payment variation across areas, particularly among plans within the same area, does not seem to be justified. There are areas where payments are such that risk plans can provide extra benefits. At the same time, payment rates may be too low in other areas, discouraging plans from participating in the program.

In our upcoming report, the Commission recommends several changes to the current system that would result in more appropriate payment levels. These include removing special payments associated with teaching and disproportionate share hospitals, accounting for services provided in military and veterans' facilities, and making other changes that would increase minimum payment levels and further reduce payment variation. I would like to discuss each of these issues in turn.

Removing Special Payments—Part of the variation in risk payment rates relates to Medicare fee-for-service payment policies that may not reflect the way managed care organizations operate. Because of the way they are determined, the capitation

rates include special payments to hospitals that have graduate medical education programs or serve a disproportionate share of low-income patients. Risk plans, however, are not required to use these providers, or pass along these extra payments to them. Consequently, the capitation rates in these areas may be higher than risk plans' costs.

The Commission believes teaching and disproportionate share payments should be removed from the calculation of risk payments. In 1995, these special payments represented about 5.3 percent of total Medicare program spending, with wide variation at the county level. Among the 30 counties with the greatest risk enrollment in 1995, teaching and disproportionate share payments ranged from 1 percent of total fee-for- service spending to almost 20 percent.

This change would reduce the rates the most in counties where fee-for-service spending is higher because of these special payments. In most counties, however, the amount of these payments is low so that risk payment rates would change only slightly. The Commission also believes a separate mechanism should be developed to make additional payments to teaching and disproportionate share hospitals for the Medicare risk plan enrollees they treat. This is necessary to preserve Medicare beneficiaries' access to care in these facilities and to continue Medicare's support for the special roles these institutions play in teaching, research, and serving the poor.

Accounting for VA and DoD Services—Another source of variation is due to services received by Medicare beneficiaries in facilities operated by the Departments of Veterans Affairs and Defense that are not accounted for in Medicare's calculation of fee-for-service rates. In those areas where risk enrollees do not use these facilities to the same extent as beneficiaries in the fee-for-service system, risk payments may be too low. In areas with little risk enrollment, these lower rates might discourage risk plan participation. If payment rates were increased in these areas, adjustments might be needed for those risk enrollees that continue to use DoD or VA facilities.

Other Changes—Even with the modifications I have just mentioned, the Commission believes that other changes are necessary to improve capitation payments. In some areas, payment rates may need to be increased to a minimum level to provide adequate payment for the costs of providing Medicare services. This may be especially important in rural areas where sparse populations and less developed health care infrastructures add additional cost requirements for plans. Any increase in payments, however, should be offset either by reducing all payment rates above the minimum level or by lowering the highest rates.

Overall variation in capitation rates could be constrained in several ways. One way would be to blend local amounts with the national average rate, bringing all payments closer to the average.

Updating Risk Payments

In addition to recommending changes to risk plan base payment rates, the Commission believes that the method for updating payments must be replaced. Currently, risk payments change each year based on the spending experience in the fee-for-service sector. Because spending in many areas is quite variable, there can be profound changes in risk payments from year to year—especially in counties with few beneficiaries. For example, between 1996 and 1997, the payment rates for several counties jumped by 25 percent or more, while other counties experienced payment decreases of 10 percent or more (see Chart 5). Even for relatively large counties, the rates can vary substantially from year to year. Moreover, the problem can be compounded in areas where relatively healthy beneficiaries are choosing to enroll in risk plans. In those areas, risk plan payment increases are based on the higher spending patterns of sicker beneficiaries remaining in the fee-for-service system. Thus, the payment rates may become increasingly out of line with the costs of serving the risk enrollee population.

Mr. Chairman, this method of updating risk payments is flawed on several fronts. First, and perhaps most importantly, the method provides no way for Medicare to share in savings that occur when risk plan costs increase more slowly than the payment rate. Any difference between payments and costs goes towards extra benefits to enrollees. While extra benefits may be useful to attract beneficiaries, Medicare has no means for retaining any of the excess payment.

Second, updating risk plan payments based on changes in fee-for-service spending may not reflect the performance of managed care plans in providing services to risk enrollees. The fee-for-service system is fundamentally different than managed care. Spending growth under fee-for-service is driven in large part by increases in the volume and intensity of services provided, which reflect fee-for-service payment incentives. A capitated system, by contrast, seeks to control the volume of services provided. In addition, unlike the fee-for-service system, risk plans can negotiate lower

prices with providers and can sometimes shift patients from more expensive settings to less costly ones.

The current system for updating risk payment rates should be discarded and replaced by a method that is analytically-based. A formula approach similar to one the Commission uses to recommend hospital payment increases should be implemented. Such a framework would consider factors that are likely to affect plan costs, such as inflation and industry productivity improvements. In this way, Medicare could break the link to fee-for-service spending and permit Medicare to share in the savings associated with any increase in efficiency.

Longer Term Changes to Risk Payments

The Commission believes that risk payments should be based on the costs that an efficiently run plan would be expected to incur in providing Medicare-covered services. As you know, however, this level is difficult to determine. While the Commission believes its recommended changes to the current system will improve the risk payment methodology, it also believes Medicare should begin looking at alternative ways for determining capitation rates. Market-based methods such as competitive bidding and third-party negotiations should be explored. These approaches also would break the link to fee-for-service spending and permit Medicare to take advantage of many of the same forces private sector purchasers have successfully relied on to reduce their health care costs.

RISK PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

Changes to the risk payment methodology are necessary to ensure the success of the risk program. These changes have the potential to affect HMO participation in the program as well as beneficiary enrollment. Participation and enrollment could rise in areas where payment levels are increased but could fall in areas where rates are reduced. The likely impact of any changes, however, is difficult to quantify because participation and enrollment depend upon a number of factors. The changes we recommend, however, likely would differ little from changes that any prudent purchaser would impose given similar circumstances.

A recent ProPAC analysis found that HMOs are more likely to participate in the risk program in urban areas with higher payment rates. At the same time, however, there are areas with relatively low payment rates where HMOs participate in the risk program and areas where there is minimal participation despite relatively high payment rates. This suggests that characteristics of the market as well as of the HMO itself also play a role in participation decisions. ProPAC analyses indicate that larger and older HMOs are more likely to participate. This may indicate that success in the commercial market is an important factor in an HMOs decision to enter the risk market. The extent of risk plan competition in an area also influences participation decisions; HMOs are less likely to enter a market where they would face a number of competitors.

Consequently, decisions to participate in the risk program involve a complex decisionmaking process, of which payment rates are only one factor. If faced with lower payment rates, participating plans can choose to not renew their contracts, but there are less drastic alternatives that plans might pursue. Plans could lower their costs through tightening administrative spending, accepting lower profits, or negotiating more stringent rates with providers. They also could reduce the level of extra benefits they offer beneficiaries.

Raising payment rates in certain areas would encourage participation, but other factors may limit HMOs' responses. For example, provider shortages and sparse populations may have a greater influence on plan decisions in rural areas. I should point out that participation may increase in all areas if the Congress decides to expand the program to include additional entities, such as provider service organizations. This may be especially relevant in rural areas where providers who already serve Medicare beneficiaries may choose to develop these entities. Again, however, many factors are likely to come into play.

The impact of rate changes on beneficiary participation also is unclear. A primary reason why Medicare beneficiaries join risk plans is because they can receive extra non-Medicare covered services at no additional costs. ProPAC analyses indicate that plans serving areas with higher payment rates tend to provide richer benefit packages (see Chart 6). But like plan participation decisions, the level of extra benefits offered by plans is influenced by other factors as well. For example, plans in more competitive areas tend to provide a higher level of extra benefits than plans that have little or no risk plan competition.

Limiting payment rates may reduce the level of extra benefits that risk enrollees would receive. Given the relatively generous extra benefits in high payment areas,

it is likely that beneficiaries in these areas would still receive some amount of extra benefits, regardless of any payment reductions. In addition, plans may have other incentives, such as competitive pressures, to forego a share of their profits to maintain a competitive benefit package. It also is possible that as more commercial managed care enrollees age into Medicare, they may choose to continue their coverage under a managed care arrangement, regardless of the level of extra benefits.

IMPROVING RISK PLAN INFORMATION

Mr. Chairman, as the risk program continues to expand, it is increasingly important that the program have sufficient information to ensure that risk payments are appropriate and that plans are delivering quality care. In addition, beneficiaries need to have comparative information to make informed choices between competing risk plans, or choosing between the risk option and remaining in fee-for-service.

Currently, discussions about risk plan payments and costs are hindered because there are no data available on the actual costs risk plans incur to provide Medicare services. The only cost data available are from the adjusted community rate (ACR) proposals that plans annually submit to HCFA. These proposals, used to determine the level of extra benefits that risk plans are required to offer, set forth plans' projected costs in providing the Medicare-covered benefit package, including administrative outlays and profit.

The process used to arrive at these projections is indirect. Plans estimate the monthly per enrollee costs needed to provide the Medicare benefit package to their commercial population and then adjust these estimates upward to reflect the higher usage rates of an older, sicker Medicare population. There is no mechanism to learn whether, and to what extent, risk plans' actual Medicare costs are above or below their projections.

These cost projections may be particularly distorted because of the method plans use to calculate their Medicare administrative costs and profit estimate. Risk plans apply the share of their commercial costs that is devoted to administration and profit to their estimated Medicare patient care costs to obtain this estimate. Because Medicare's service-related costs are, on average, about triple those in the private sector, the amount of costs attributable to Medicare administration and profit is also about three times higher. According to ProPAC analyses of 1995 data, plans estimated they would receive, on average, about $20 per month to cover administrative costs and profit associated with each commercial enrollee. Because of the allocation formula, however, these items accounted for about $66 of risk plans' projected Medicare costs per member per month. I should note that these costs do not affect the payment that plans receive, but rather can alter the level of additional benefits that plans may be required to offer beneficiaries.

The Commission recommends that the Secretary require plans to provide information to assess the costs of furnishing services to Medicare enrollees. This information is needed to evaluate the appropriateness of plan payments as well as the relationship between payments and costs of care. This information could also be used to assess whether plans are returning appropriate amounts of excess payments to beneficiaries through extra benefits. This data collection would not need to be overly burdensome. It could be obtained through a process similar to that of preparing the current ACR proposal.

Information to monitor and assess the quality of care provided by risk plans also is needed. In a managed care environment where there are incentives to provide less rather than more care, concerns about the quality of care are heightened. The Commission supports the Secretary's efforts to evaluate Medicare risk plans through the use of the Health Plan Employer Data and Information Set (HEDIS) and enrollee satisfaction surveys. While this is a good first step, the Commission believes that quality measurement tools should be evaluated continually and modified to improve the evaluation of plan performance.

Finally, as the risk program expands, more and more beneficiaries will have the choice of enrolling in a risk plan, and choosing among risk plans. To date, beneficiaries have not had adequate information for making these choices. Information about the risk option furnished by Medicare has been general and provided only to new beneficiaries or those who request it. This year, HCFA will introduce a number of initiatives to improve the information beneficiaries can use to decide whether to join a risk plan. ProPAC believes that all beneficiaries should receive quality and satisfaction data about risk plans as well as the fee-for-service system. In this way, beneficiaries can make informed decisions about which option is better for them.

CONCLUSION

As Medicare managed care continues to expand, the growth in overall Medicare spending will depend increasingly on the performance of the risk program. This program has the potential to restrain Medicare spending, but only if problems with the payment methodology are addressed. Relying on the current risk adjustment methods and fee-for-service spending distorts risk plan payments. Changes that move towards breaking this link would permit Medicare to fulfill its role as a prudent purchaser of quality health care services for its beneficiaries.

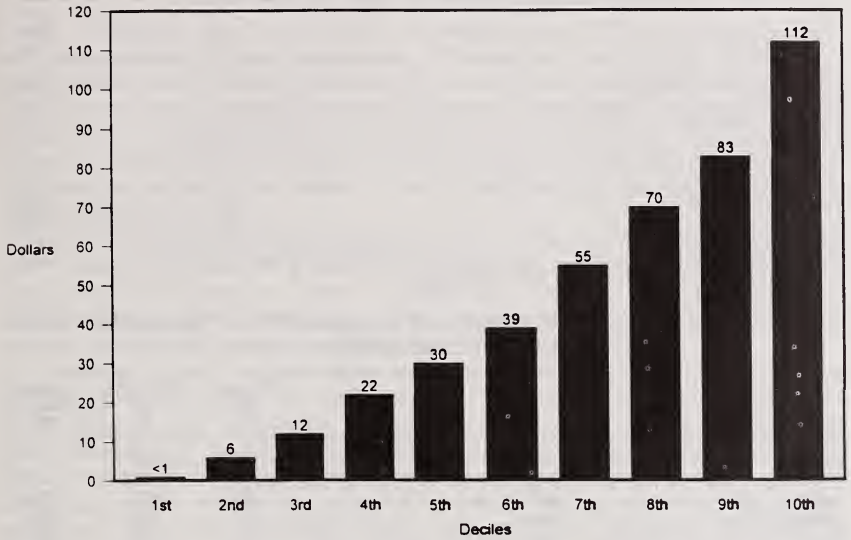
This concludes my formal statement, Mr. Chairman. I would be pleased to answer any questions from you or other members of the Subcommittee.

Chart 1. Medicare Risk Program Participation, 1990-1997

Year*	Enrollees		Contracts**
	Number (In Millions)	As a Percentage of Total Medicare Enrollment	
1990	1.2	3.5	95
1991	1.3	3.7	85
1992	1.5	4.2	83
1993	1.7	4.7	90
1994	2.1	5.7	109
1995	2.9	7.7	154
1996	3.9	10.4	189
1997 (Jan)	4.2	11.0	248

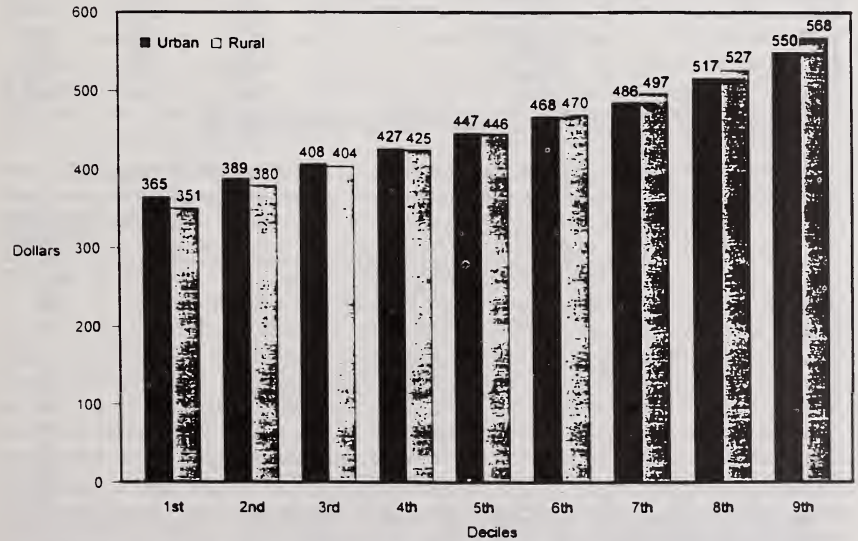
*Enrollment data are as of September each year with the exception of 1997.
**Data are as of January each year.
SOURCE: Health Care Financing Administration, Office of Managed Care.

Chart 2. Standardized Value of Extra Benefits Offered by Medicare Risk Plans, Plan-Level Deciles, 1995



SOURCE: ProPAC analysis of 1995 Medicare risk plan adjusted community rate proposals.

Chart 3. Standardized Medicare Risk Plan Aged Monthly Payment Rates for Urban and Rural Counties, 1997



Note: Payments are standardized by adjusting 70 percent of the rate by the applicable PPS hospital wage index.

SOURCE: ProPAC analysis of 1997 risk plan payment data from the Health Care Financing Administration, Office of Managed Care.

Chart 4. Medicare Aged Risk Plan Rates for the Washington, DC Metropolitan Statistical Area, by Selected Counties, 1997

County	Monthly Payment Rate
Prince George's County, MD	$602
Washington, DC	584
Montgomery County, MD	492
Arlington County, VA	451
Falls Church City, VA	447
Alexandria City, VA	447
Manassas Park City, VA	443
Fairfax City, VA	417
Fairfax County, VA	401

SOURCE: Health Care Financing Administration, Office of the Actuary.

Chart 5. Counties With the Biggest Increases and Decreases in Medicare Managed Care Monthly Payment Rates for Aged Enrollees Between 1996 and 1997

County	State	1996 Monthly Rate $	1997 Monthly Rate $	Percentage Change in rates
Culberson	Texas	355	487	37.0
Refugio	Texas	370	493	33.2
Logam	West Virginia	499	642	28.5
Southeast Fairbanks	Alaska	313	395	26.2
Crane	Texas	365	458	25.5
Coleman	Texas	350	438	25.1
Washabaugh	South Dakota	281	348	24.2
Latimer	Oklahoma	308	382	24.0
Robertson	Kentucky	304	372	22.3
Caldwell	Louisiana	539	658	22.1
Rio Blanco	Colorado	457	410	–10.3
Webster	Nebraska	264	236	–10.6
Hanson	South Dakota	381	339	–11.0
Esmeralda	Nevada	568	504	–11.3
Dolores	Colorado	346	306	–11.7
Rich	Utah	310	272	–12.1
Buffalo	South Dakota	437	363	–16.8
Gilliam	Oregon	345	286	–17.0
Delta	Colorado	500	381	–23.8
Loving	Texas	881	527	–40.2

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Managed Care.

Chart 6. Characteristics of Medicare Risk Plans, by Risk Plan Payment Index, 1995

Decile	Average Plan Payment Index*	Average Standardized Value of Extra Benefits**
All	1.09	$43
10 (highest)	1.37	80
9	1.23	49
8	1.20	54
7	1.16	45
6	1.13	54
5	1.09	50
4	1.04	33
3	0.96	15
2	0.89	29
1 (lowest)	0.83	21

*Represents the level of payment relative to the national average. For example, a payment index of 1.37 means that payments are 37 percent greater than the national average.

**Amounts are standardized by adjusting 70 percent of the value by the applicable hospital wage index.

SOURCE: ProPAC analysis of data from the Health Care Financing Administration, Office of Managed Care and Bureau of Data Management and Strategy.

Mr. BILIRAKIS. Thank you. Thank you, sir. I guess we will go on to Dr. Ratner at this point.

STATEMENT OF JONATHAN RATNER

Mr. RATNER. Mr. Chairman and members of the subcommittee, we are pleased to be here today to discuss Medicare's HMO payment rates and how to improve their accuracy. As you know, at the request of the House Ways and Means Committee's Subcommittee on Health, we reviewed HCFA's method for setting HMO rates to identify feasible options for promptly reducing the amount of excess payments. A full discussion of our findings will be published in a forthcoming report.

Today I would like to focus my comments on a modification we identified to Medicare's HMO rate-setting method that could help improve its accuracy. Our modification targets the adjustments where the excess payments are occurring rather than reducing payments across the board, unfairly affecting some HMOs.

I would like to make four points. First, HCFA's method sets HMO rates based on an inflated cost average. Central to the current method and proposals for change is an estimate of the average cost, county by county, of serving Medicare beneficiaries under fee for service. HCFA's method of determining the county cost average excludes HMO enrollees' costs. The result is that in counties experiencing favorable selection—the tendency of HMOs to attract a healthier than average mix of beneficiaries—HCFA's method will overstate the average cost of all Medicare beneficiaries and lead to overpayments.

Second, our proposed modification yields a more accurate cost average and would save hundreds of millions of dollars in excess payments annually. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information that is available to HCFA, overcoming the difficulty that HCFA cannot directly observe enrollees' costs. Our approach produces a county rate that more accurately represents the costs of all Medicare beneficiaries.

Now to illustrate the effect of our modification, we analyzed data for counties with very different shares of beneficiaries enrolled in HMOs. We found that the application of our approach could have reduced excess payments by about one-fourth. For the counties that we analyze, which contain 36 percent of all Medicare HMO enrollees, our modification could have reduced payments $276 million in 1995. Despite the size of these savings, our modification would have produced changes in the counties' monthly payment rates that would be relatively small, ranging from $3 to $38.

Now it is sometimes suggested that the excess-payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs contain a more expensive mix of beneficiaries. Our analysis did not support this hypothesis. Our data, which include counties with up to 39 percent HMO penetration, indicate that overstatement of the county cost average is most often greater in counties with higher Medicare HMO penetration. In fact this overstatement of costs tends to increase as HMO enrollment increases.

Third, our modification is feasible technically and administratively. We believe our approach has important advantages due to its use of data that HCFA routinely compiles to update HMO rates.

HCFA could put our modification in place in a relatively short time. The time element is important, because many of the HMO rate options being considered and that we have heard about will use HCFA's current county AAPCC rates as a baseline to set future rates.

Implementing our modification would avoid locking in any of the current rates that are excessive. In addition, not requiring collection of any new data also makes our proposal economical. The savings gained from reducing county rate excess payments should be much greater than the administrative cost of implementing our modification.

Fourth, our modification is useful under several possible scenarios, whether the Congress adopts any proposal that uses county average costs as a baseline, whether HCFA adopts an improved risk adjuster, or whether Medicare's current rate-setting process remains in place.

In conclusion, many fear that enrolling more beneficiaries in managed care could increase rather than lower Medicare spending unless Medicare's method of setting HMO rates is revised. Our approach to sharpening the accuracy of the estimate of county rate average cost would lessen the risk of overpayment and could lower Medicare expenditures by at least several hundred million dollars each year. Moreover, this approach to curbing excess payments is targeted, reducing payments more for HMOs in counties with higher excess payments, and less for HMOs in counties with lower excess payments. Finally, it complements other reforms, such as improved risk adjusters, but it can be put in place promptly, without waiting for action on other fronts.

Mr. Chairman, this concludes my statement. I would be pleased to answer any questions.

[The prepared statement of Jonathan Ratner follows:]

PREPARED STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss the rates Medicare pays health maintenance organizations (HMO) in its risk contract program, Medicare's principal managed care option.[1] As you know, Medicare's method for paying risk contract HMOs was designed to save the program 5 percent of the costs for beneficiaries who enroll in HMOs. However, 10 years of research on Medicare's costs under HMOs has found that the program's rate-setting method results in excess payments to HMOs because HMO enrollees would have cost Medicare less if they had stayed in the fee-for-service sector.[2] Recently, the Physician Payment Review Commission (PPRC) estimated that annual excess payments to HMOs nationwide could total $2 billion.[3]

A number of proposals have been made recently to help alleviate Medicare's HMO payment problems. For example, the proposed Balanced Budget Act of 1995 called for, among other things, mechanisms to lessen rate disparities across geographic areas and to decouple annual HMO rate increases from annual fee-for-service spending increases. The administration's current budget proposal adopts several provisions from the proposed Balanced Budget Act but also adds new twists-such as an across-the-board reduction in Medicare's HMO payments that would lower the pay-

[1] Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this statement.

[2] See the attached list of related GAO products.

[3] This estimate was contained in material presented to the Commissioners for their December 12-13, 1996, meeting.

ments from 95 percent to 90 percent of estimated fee-for-service costs. Under the auspices of the Health Care Financing Administration (HCFA), which administers the Medicare program, several demonstration projects are planned or under way, including efforts to improve risk adjustment and using a process of competitive bidding to set rates.

At the request of the Chairman, Subcommittee on Health and Environment, House Committee on Commerce, we reviewed HCFA's method for setting HMO rates to identify feasible options for promptly reducing the amount of excess payments. A comprehensive discussion of our work is included in a forthcoming report. In conducting our study, we reviewed previous research on Medicare's HMO rate-setting method, analyzed available HCFA data, and had our findings reviewed by experts on HMO payment issues, including staff at PPRC and HCFA.

Today, I would like to focus my comments on our proposed modification to HCFA's HMO rate-setting method. We believe this modification could help reduce excess HMO payments under Medicare's current payment method, the administration's method, or other methods that rely on fee-for-service costs to set initial HMO rates or update those rates. Central to the current method and proposals for setting HMO rates is an estimate of the average cost of serving Medicare beneficiaries under fee-for-service in defined geographic areas (currently, counties). The actual rates paid HMOs for an enrollee are set by adjusting these averages up or down based on the enrollee's "risk" of incurring higher or lower costs. Considerable attention has focused on the failure of current risk adjustment methodology to adequately account for favorable selection, the term used to describe the tendency of HMOs to attract a population of Medicare seniors whose health costs are generally lower than those of the average beneficiary. Our work centers on the estimate of average cost of serving a county's beneficiaries: the county rate.

In summary, we found that HCFA's current method of determining the county rate produces excess payments. Because HCFA's method excludes HMO enrollees' costs from estimates of the per-beneficiary average cost, it bases county payment rates on the average per-beneficiary cost of only those beneficiaries that remain in the fee-for-service sector and ignores the costs HMO enrollees would have incurred if they had remained in fee-for-service. Research has shown the costs of those remaining in fee-for-service to be higher on average than the likely costs of HMO enrollees. A difficulty in correcting the problem is that HCFA cannot directly observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Our proposed modification is designed to fix that problem. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our approach produces a county rate that represents the costs of all Medicare beneficiaries and could result in hundreds of millions of dollars in savings to Medicare.

HOW MEDICARE DETERMINES AN HMO'S PAYMENT RATE

Essentially, HCFA's calculation of its per-enrollee (capitation) rate can be expressed as follows: **Capitation rate = average per-beneficiary cost x .95 x risk adjustment factor**

Medicare pays risk HMOs a fixed amount per enrolee—a capitation rate—regardless of what each enrollee's care actually costs. Medicare law stipulates that the capitation rate be set at 95 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service.[4] In implementing the law's rate-setting provisions, HCFA estimates a county's average per-beneficiary cost and multiplies the result by 0.95.[5] The product is the county adjusted average per capita cost rate.[6]

HCFA then applies a risk-adjustment factor to the county rate. Under HCFA's risk-adjustment system, beneficiaries are sorted into groups according to their demographic traits (age; sex; and Medicaid, institutional, and working status). HCFA calculates a risk factor for each group-the group's average cost in relation to the cost of all beneficiaries nationwide. For example, in 1995 the risk factor for younger seniors (65- to 70-year-old males) was .85, whereas for older seniors (85-year-old or older males) it was 1.3. HCFA uses the risk factor to adjust the county rate, thereby

[4] Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4) (1994)).

[5] A 5-percent discount is taken on the premise that, compared with fee-for-service care, managed care plans achieve certain efficiencies. For example, HMOs can negotiate with hospitals, physicians, and other providers to obtain discounts on services and supplies.

[6] Medicare determines four capitation rates for each county, one each for part A aged, part B aged, part A disabled, and part B disabled.

raising or lowering Medicare's per capita payment for each HMO enrollee, depending on the individual's demographic characteristics.

MEDICARE'S HMO RATE-SETTING METHOD HAS LED TO EXCESS PAYMENTS

One reason the HMO rate-setting method overstates the expected fee-for-service costs of HMO enrollees is that it uses only the cost experience of fee-for-service beneficiaries. If the health status of the mix of beneficiaries enrolled by HMOs were the same as the health status of those in fee-for-service, using fee-for-service beneficiaries to estimate the expected fee-for-service costs of HMO enrollees would be an appropriate method. However, because research has shown that HMOs have in general attracted healthier-than-average beneficiaries, the beneficiaries remaining in fee-for-service represent a sicker-than-average population.[7] This, in turn, means that using data on fee-for-service beneficiaries exclusively produces HMO payment rates higher than envisioned when the current rate setting provisions were enacted.

Medicare's risk adjustors explain about 3 percent of the variation in individual-level health care costs and are thus not adequate to account for the cost differences among beneficiaries. The difficulty is that, within the same demographic group, HMO enrollees are healthier than fee-for-service beneficiaries; for example, 70-year-old males in HMOs are, on average, healthier than 70-year-old males in fee-for-service. Medicare's risk adjustor is said to be inadequate because, while it makes broad distinctions among beneficiaries of different age, sex, and other demographic characteristics, it does not account for the significant health differences among demographically identical beneficiaries. The cost implications of health status differences can be dramatic-for two demographically alike beneficiaries, one may experience occasional minor ailments while the other may suffer from a serious chronic condition.

INCLUDING HMO ENROLLEES' COSTS IN COUNTY AVERAGE IMPROVES ACCURACY OF COUNTY RATES

Independent of improved risk adjustment, modifying the method for calculating the county rate would help reduce Medicare's excess HMO payments. In setting county rates, HCFA currently estimates the average Medicare costs of a county's beneficiaries using the costs of only those beneficiaries in Medicare's fee-for-service sector. This method would be appropriate if the average health cost of fee-for-service beneficiaries were the same as that of demographically comparable HMO enrollees. However, in counties where there are cost disparities between Medicare's fee-for-service and HMO enrollee populations, this method can either overstate the average costs of all Medicare beneficiaries and lead to overpayment or understate average costs and lead to underpayment. Correcting this problem is difficult because it is impossible to observe the costs HMO enrollees would have incurred had they remained in the fee-for-service sector. Therefore, we developed a method to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our method consists of two main steps:

—First, we compute the average cost of demographically similar new HMO enrollees during the year before they enrolled—that is, while they were still in fee-for-service Medicare. These fee-for-service costs are available through HCFA's claims data.

—Next, we adjust this amount to reflect the expectation that a new enrollee's use of health services will, over time, rise.[8]

Having completed these steps, we combine the result with an estimate of the average cost of fee-for-service beneficiaries. This new average produces a county rate that reflects the costs of all Medicare beneficiaries.

Selected 1995 County Rates Produced Substantial Excess Payments

To illustrate the effect of our approach, we analyzed data for counties with different shares of beneficiaries enrolled in HMOs. We chose counties within a single state to eliminate variations attributable to state differences. We selected California because it covers 36 percent of all Medicare HMO enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. We found that our

[7] HCFA's *Health Care Financing Review*, a 1996 study using postdisenrollment data, estimated that HMO enrollees' costs were 12 percent lower than average, while a 1996 PPRC study using preenrollment data estimated that enrollees' costs were 37 percent lower than for comparable fee-for-service beneficiaries.

[8] Our analysis adjusts for (1) the tendency for enrollees' costs to become more like—or "regress" toward—the fee-for-service cost mean after joining an HMO and (2) the costs incurred by HMO enrollees who die while enrolled. How our method accounts for these costs is discussed more thoroughly in our report.

method could have reduced excess payments by more than 25 percent. Although better risk adjustors could further reduce the large remainder of excess payments, improvements to risk adjustment require developing direct measures of health status, which is a complex effort that may take years.

The following key points also emerged from our analysis:

—First, for the counties that we analyzed, we estimate that total excess payments in 1995 amounted to about $1 billion (of about $6 billion in total Medicare payments to risk HMOs in the state). Of that amount, applying our method for setting county rates would have reduced the excess by about $276 million.

—Second, the excess payments attributable to inflated county rates were concentrated in 12 counties with large HMO enrollment and ranged from less than 1 percent to 6.6 percent of the counties' total HMO payments, representing between $200,000 and $135.3 million.[9] Despite the size of these amounts, the application of our method would have produced relatively small changes in the monthly, per-beneficiary capitation payments, ranging from $3 to $38.

—Third, our analysis did not support the hypothesis, put forward by the HMO industry and others, that the excess payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs progressively enroll a more expensive mix of beneficiaries. Our data-which include counties with up to a 39-percent HMO penetration-indicated that the disparity between Medicare rates and our rates is larger in counties with higher Medicare penetration. For example, the four counties with the highest rates of excess payment in 1995, ranging from 5.1 to 6.6 percent, were also among the counties with the highest enrollment rates.

Data Are Available to Enable HCFA to Promptly Adjust County Rates

Because the data we used to estimate HMO enrollees' costs come from data that HCFA compiles to update HMO rates each year, our method has two important advantages. First, HCFA's implementation of our proposal could be achieved in a relatively short time. The time element is important, because the prompt implementation of our method would avoid locking in a current methodological flaw that would persist in any adopted changes to Medicare's HMO payment method that continued to use current county rates as a baseline or fee-for-service costs to set future rates. Second, the availability of the data would also make our proposal economical: we believe that the savings to be achieved from reducing county-rate excess payments would be much greater than the administrative costs of implementing the process.

CONCLUSIONS

Medicare's HMO rate-setting problems have prevented it from realizing the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. In fact, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending—unless Medicare's method of setting HMO rates is revised. Our method of calculating the county rate would have the effect of reducing payments more for HMOs in counties with higher excess payments and less for HMOs in counties with lower excess payments. In this way, our method represents a targeted approach to reducing excess payments and could lower Medicare expenditures by at least several hundred million dollars each year.

Furthermore, our approach is useful under several possible scenarios, including whether (1) the Congress adopts any proposal that uses current county rates as a baseline, (2) HCFA develops and adopts improved risk adjustors, or (3) the Congress and HCFA take no action, thus preserving Medicare's current rate-setting process.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions.

RELATED GAO PRODUCTS

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States (GAO/HEHS-96-63, Jan. 18, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

Mr. BILIRAKIS. Thank you, Doctor.

[9] For the state's remaining 46 counties, excess payments attributable to inflated county rates amounted to less than 3 percent of the 58-county total.

Dr. Taylor.

STATEMENT OF ROGER S. TAYLOR

Mr. TAYLOR. Good afternoon, Mr. Chairman, and members of the committee.

In my brief remarks I will be referring to Figures 1 through 10 at the back of the PPRC statement that you have in front of you.

Figure 1, Mr. Chairman, simply confirms your opening remarks. The number of Medicare beneficiaries in HMOs has grown rapidly in the last 5 years. While that is impressive, the growth still lags significantly behind the managed care penetration in the commercial marketplace.

Figure 2 documents the wide geographic variation in managed-care enrollment that many of you have been talking about, from over 50 percent of beneficiaries in some California cities to virtually none in Atlanta and Detroit. Further about 20 percent of urban beneficiaries are enrolled but only about 1 percent of rural care members are enrolled.

Figure 4 just shows the growth in risk plans. We have had a rapid growth in the last few years. About 260 plans are now Medicare risk plans, but there is still quite a bit of skew in the distribution of those. Only 63 percent of the population has one or more plans to choose from. Thirty-seven percent have none, and a full 80 percent of rural beneficiaries have no plan available.

Figure 5 drives home the point that's been discussed now by a number of the speakers and that is why there is such wide geographic variation is the difference in payment. Nationally there is over a $550 per month difference between high county and low county payment. This difference really can't be explained by a difference in health status. Not unexpectedly Medicare risk plans are attracted to areas with high payments. With those higher payments and the efficiencies, they bring, they add substantial new benefits. Our analysis suggests that these have an average of $69 per month in extra value above and beyond Medicare's benefits with no extra cost. You see an analysis of where those are in that chart.

The majority of managed care plans in fact charge no additional premium at all for these extra benefits.

According to PPRC's analysis, these extra benefits and cost savings are really the major reason why folks join Medicare HMOs. Some of the studies have suggested that part of the cost savings are actually the result of Medicare overpayment to HMOs.

On Figure 8 you will see an analysis that PPRC did of the enrollees' use of health care services in the 6 months prior to joining an HMO and use of services in the 6 months after enrollment of those 3 percent leaving HMOs back to fee-for-service. You will see that there is a significant suggestion there that there is a favorable risk selection of folks going into the HMO who are using only 63 percent of normal services prior to joining.

Even if the difference in health care cost levels off after the first 2, 3 years of HMO membership as some suggest, it could still result in significant overpayment as seen in Figure 9.

Our study of five large plans suggests that nearly 30 percent of HMO members have been enrolled 2 years or less, and 40 percent

3 years or less. Further, this relative overpayment can be compounded by the fact that the AAPCC does include earmarked funds—the GME and DSH that you have been discussing—for activities that HMOs may or may not be involved with.

The commission has made a number of recommendations to address these issues and a full list of those are in Figure 10. I would like to just very briefly mention five here.

The commission has made three recommendations for technical improvements to the AAPCC.

First, implement better risk adjusters. We feel that we could begin doing that now with the available administrative data, and improve on that process phasing it in over time. We don't need to wait.

Second, remove earmarked funds of GME and DSH. At the same time create a separate mechanism to assure that hospitals, health plans and others are paid fairly for the appropriate training that they do.

Third, modify the geographic basis of payment. This could be done by expanding the base beyond county lines or linking risk payments from local spending and blending in local and national rates. Also, the trimming through floors and ceilings would be another means that we have analyzed. In fact, the commission has really done extensive modelling of all three of these possibilities and would be glad to prepare those for Staff.

The commission has also recommended that HCFA continue to test alternative methods for setting local payment rates including competitive bidding, partial capitation, and reinsurance.

Finally, the commission recommends that Congress consider the net effect of these many changes that are being considered and design a phase-in program so that the changes being made do not have a disruptive effect on beneficiaries and plans.

Mr. BILIRAKIS. Did you want additional time, Dr. Taylor? Do you feel you have gone through your——

Mr. TAYLOR. Just in conclusion, last year the commission did extensive analysis on the possible effects of different changes being proposed and the net effect and phased-in effect and we would be very pleased to do similar work this year.

[The prepared statement of Roger S. Taylor follows:]

PREPARED STATEMENT OF ROGER S. TAYLOR, COMMISSIONER, PHYSICIAN PAYMENT REVIEW COMMISSION

Mr. Chairman and members of the Committee, I am pleased to present the Physician Payment Review Commission's views and recommendations on several issues related to payment under Medicare managed care. Expansion of managed care and introduction of new private health plan options for Medicare beneficiaries present both opportunities and challenges. The Commission has been working closely with congressional committees and staff to provide analysis and recommendations that can help inform your deliberations. Any policy changes should further the goals of ensuring Medicare's financial solvency and beneficiary access to timely, appropriate health care services. Accomplishing these goals, however, creates a tension between setting payments that are high enough to provide access but are also affordable.

Over the past decade, there has been tremendous change in how Americans pay for and receive health care. Pressures to reduce growth in health care spending have created a new awareness among consumers, purchasers, and providers of the tradeoffs that arise when resources are finite. Managed care has grown in part because of purchasers and consumers' willingness to trade limits on choice for lower health costs.

Medicare can learn from the experience of the private sector. In fact, as commercial managed-care penetration grows and managed-care enrollees age into Medicare, it is inevitable that more and more beneficiaries will select this option within Medicare. But it is important to keep in mind that Medicare differs in important ways. First, Medicare managed-care enrollment, while growing, still lags substantially behind commercial enrollment (Figure 1). Second, although managed-care growth in the private sector has been associated with reduced cost growth, under current policy, this does not appear to be the case for Medicare. In fact, some studies suggest that managed care growth *increases* program outlays. Third, the private market encompasses a broader range of plan options than Medicare currently permits, but most individuals with employer-based insurance have only a limited number of plans to choose from.

The debate on Medicare managed care always eventually turns to payment. Changes in payment policy could serve several goals: reducing program spending, encouraging managed-care enrollment by making the program more attractive to plans in certain markets, and improving equity by reducing the variation in benefits offered by Medicare managed-care plans in different areas of the country. My testimony this morning focuses on these issues and the range of policy options that could be adopted. The challenge facing policymakers is to develop an approach to paying plans that is fair, reduces cost growth, and ensures that beneficiaries have access to appropriate care at a cost they can afford.

My statement begins with some brief background information about Medicare managed care and the issues that will arise as managed care choices expand. I will then sketch out how Medicare now pays managed-care plans and the problems associated with current policy which the Commission and others have identified. Finally, I will talk about the different options that the Congress could take to address these problems (including those included in the Balanced Budget Act passed in the last Congress and the President's recent budget proposal) as well the Commission's recommendations concerning implementation of these options.

MEDICARE MANAGED CARE: PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

As you know, Medicare managed care is growing. By the end of 1996, about 13 percent of Medicare beneficiaries were enrolled in some form of managed care, compared to 5 percent in 1990. Participation by beneficiaries varies widely, with over 20 percent of urban beneficiaries enrolled in managed care, compared to about 1 percent of rural beneficiaries. Although predominantly an urban phenomenon, enrollment rates differ across urban areas. Over half of beneficiaries in Riverside, CA, are in risk plans, for example, while virtually none are in Atlanta and Detroit (Figure 2).

Most plans participate in Medicare through the risk-contracting program. Under a risk contract, plans commit to providing Medicare-covered services to beneficiaries for a fixed monthly payment from the program. There were 241 risk contracts in effect at the end of 1996; 17 more have been added in the last two months (Figure 3).

The availability of risk plans varies widely across the nation. In most urban areas, beneficiaries can choose among several plans, while 80 percent of rural beneficiaries have no plan available. Overall, about two-thirds of beneficiaries are served by at least one risk plan; 25 percent have access to more than four plans (Figure 4).

CURRENT POLICY AFFECTING RISK-PLAN PAYMENT, BENEFITS, AND PREMIUMS

Now let's consider the current policies that determine how much risk plans are paid and the benefits and premiums that enrollees receive. Going over a few of the basics will be helpful in understanding the problems created by these policies.

As a result of current policies and local competitive pressures, there is wide geographic variation in payments to plans, in the benefits available to beneficiaries, and in the premiums that they pay. For example, there is a three-fold difference between the lowest and highest county payment rates (Figure 5). Over 50 percent of 1997 county rates, however, are between $340 and $440. Currently, more than three-quarters of risk plans offer additional eye and ear care, and over half provide prescription drug coverage (Figure 6). By the end of 1996, two-thirds of plans provided benefits beyond those covered by Medicare at no additional charge to enrollees (Figure 7).

Setting Payments and Benefits

Payments, benefits, and premiums are the result of two separate administrative processes, as well as of local competitive pressures.

Process for Setting Plan Payments. Payments are set to reflect local fee-for-service costs. Actual per capita spending is adjusted for differences in the characteristics of local populations. This measure, referred to as the AAPCC, is the expected local cost of caring for a typical beneficiary. Each county's payment is set at 95 percent of the AAPCC. Plans are paid this rate with an adjustment for the characteristics of their enrollees.

In setting both the local rate and the payment to a plan, adjustments are made to reflect the characteristics that affect beneficiaries' use of health care. The same five risk adjusters are used in both steps: age, sex, welfare status, institutional status, and working status. Separate adjustments are made and AAPCCs calculated for the aged, disabled, and end-stage renal patient populations.

This two-step process of setting a local rate for a typical beneficiary in each county and then adjusting payments to plans based on actual enrollment was designed with two purposes. First, expected spending on managed care should equal that in fee for service less the 5 percent savings. Second, plans should be fairly compensated for the relative risks of their enrollees.

Process for Establishing Required and Optional Benefits. The benefits and premiums that risk plans offer to beneficiaries are set in a second process. Plans submit adjusted community rate (ACR) proposals in which they estimate the cost of providing Medicare-covered services to enrollees based on the costs of serving their commercial population. If Medicare pays a plan more than these estimated costs, then the plan must return the difference to Medicare or to beneficiaries in the form of additional benefits. In practice, all plans opt to provide additional benefits to beneficiaries. The Commission estimates that in 1995, enrollees received additional benefits worth about $42 per month for which they paid no additional premium.

In response to local competition, plans may also choose to offer even more benefits. The ACR proposal establishes the maximum premium that plans can charge for these optional benefits, but plans can choose to waive all or part of this premium. In 1995, enrollees received optional benefits worth about $45 per month for which they paid an average of $18 per month.

CONCERNS ABOUT CURRENT POLICY

The wide geographic variation and volatility in spending for traditional Medicare results in large differences in the AAPCC across counties. These differences in turn affect patterns of managed-care enrollment, premiums, and benefits across the country. They may contribute to the uneven pattern of Medicare managed-care enrollment that I described earlier. And they account, at least in part, for the wide and seemingly arbitrary variation in additional benefits that Medicare beneficiaries receive from risk plans in different markets.

Several factors that could be addressed in legislation contribute to this geographic variation. The most important of these are:

- Inadequacies of current demographic risk adjusters. Inadequate risk adjustment results in increased Medicare spending in two distinct ways. First, local rates may overstate the likely cost of a typical beneficiary because the AAPCC reflects only beneficiaries who remain in fee-for-service and who have higher costs than managed-care enrollees (Figure 8). If these beneficiaries are less healthy than those in managed care and their poorer health is not captured by the current demographic adjusters, then expected fee-for-service payments are overstated. This is referred to as base-rate bias. Better adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.

  Second, in addition to the local rate being too high, inadequate risk adjustment results in overpayments to plans for their particular enrollees. Current risk adjusters explain only a small portion of the variation in health care costs among Medicare beneficiaries. A more accurate set of risk adjusters would result in lower payments to plans reflecting their relatively healthier enrollment.

  As I will explain in a moment, the Commission plans to make a series of recommendations concerning risk adjustment in its 1997 annual report to the Congress due on March 31st. Better risk adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.
- Inclusion of earmarked funds. Medicare makes payments to hospitals for graduate medical education and for serving a disproportionate share of low-income patients. Including these special funds in AAPCC-based rates contributes to geographic variation in managed-care payments. It also raises the question of whether these payments should be passed along to all managed-care plans,

since they are targeted to compensate specific hospitals for special circumstances beyond the costs of caring for Medicare patients.

The Commission has recommended that these funds could be removed from the AAPCC. A related but separate issue is whether teaching and disproportionate share hospitals should receive additional compensation for seeing managed-care enrollees or whether managed-care plans should be compensated an additional amount for teaching or serving low-income patients. The Commission recommends that mechanisms be developed to ensure that hospitals, managed-care plans, and other entities involved in training are paid fairly for these costs.

- Geographic basis of rates. Use of counties, which are relatively small geographic units, in setting payments leads to more geographic variation and volatility than may be appropriate. Variation and volatility reflect several factors, such as differences in practice patterns, difference in the health status of local populations, and, at least in some cases, small numbers of beneficiaries. Areas larger than counties would help address problems with the AAPCC and may be more consistent with the notion that managed-care plans serve markets, not counties. Using larger areas, however, loses information about the variation in health status at the county level that contributes to the accuracy of payment. For these reasons, any changes to geographic areas should be accompanied by implementation of better risk adjusters.

It is important to recognize that even if all of these technical issues were resolved, under current policy, savings from managed-care enrollment can not exceed 5 percent. Because managed-care payments increase in lock-step with Medicare fee-for-service expenditures, cost increases in fee for service drive cost increases throughout the program. Expanding managed-care without increasing outlays may require breaking the link between managed-care payments and fee-for-service expenditures.

PROPOSALS FOR CHANGE

Over the past two years, the Congress and the Administration have been considering how to set Medicare capitated rates that are fair to plans and allow the program to benefit from managed-care efficiencies. Proposals to improve risk-plan payment policies were included in the Balanced Budget Act passed during the 104th Congress. Similar proposals were introduced by Senator Daschle and supported by the Administration last year and were more recently put forward in the President's fiscal year 1998 budget proposal. All of these proposals included provisions previously recommended by the Commission.

There are basically three different ways to reduce the variation in risk-plan payment rates. These approaches could be implemented to achieve budget savings, or could be budget-neutral, focused solely on reallocating payments across areas.

The first approach is to improve the AAPCC. Improving risk adjustment, removing earmarked hospital payments, and changing the geographic basis of the local rate would all result in better estimates of patient care costs, which would differ less across areas. In its 1997 annual report, the Commission will recommend making all of these changes.

A second approach is to unlink risk payments from local spending, using current rates as a starting point for setting new rates. A variety of strategies could be used to set rates which have less geographic variation than those now based on the AAPCC. These include blending current local rates with national rates, trimming rates through floors and ceilings, and setting new ways to update local rates. Since these approaches begin with the AAPCC, the Commission recommends that if they are adopted, that they be adopted in tandem with the improvements in the AAPCC that I just mentioned.

Finally, current policy could be discarded altogether in favor of market-driven competitive solutions. Under this approach, local market characteristics would be used to set rates, either through some form of competitive bidding or a defined federal contribution for both fee-for-service and risk beneficiaries. This approach would work only in markets with sufficient local competition. It could be adapted to markets with little managed-care penetration if payments are based on the experience of both managed-care and fee-for-service beneficiaries. The Commission has recommended that the Health Care Financing Administration (HCFA) test such alternative methods for setting payments, including competitive bidding and partial capitation.

THE IMPORTANCE OF RISK ADJUSTMENT

Regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, plans will not be fairly paid for enrollees with better or worse-than-average health status

(for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for.

The Commission recommends that improved risk adjustment be implemented immediately. Although available approaches are not perfect, they would do a better job than the demographic factors currently used. As a first step, the Commission recommends that Medicare begin to phase-in risk-adjusted payment changes using administrative data. For example, our analyses and those of others would support an approach of paying less for new managed-care enrollees who have lower-than-average per capita costs. (New enrollees now account for 55 percent of Medicare managed-care enrollees, up from 43 percent in 1993.) Since risk adjustment methods typically underpredict the true variation in costs and selection, improvements such as paying moderately less for new enrollees do not risk over adjusting (that is, paying too little) for individuals with certain characteristics.

Because there are substantial differences among plans in the proportion of new enrollees, this approach would be preferable to an across-the-board cut which would particularly hurt those plans with a large proportion of long-time enrollees or those that provide specialized care for vulnerable populations (Figure 9). The President's budget proposes such a cut, setting local rates at 90 percent of the AAPCC, instead of the 95 percent under current policy. Although this would mitigate the budget impact of risk selection against the fee for service program, it would not adjust for risk selection among managed-care plans and so would not reduce plans' incentives to avoid enrolling costly beneficiaries.

Steps could also be taken immediately to improve the availability of data useful for risk adjustment. For example, hospitals are now required to submit "no-pay" bills to HCFA for hospitalized managed-care enrollees but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

Use of administrative data for risk adjustment is an important first step. Over the longer term, the data and infrastructure required to support risk adjustment should be developed and implemented. This includes obtaining data that more accurately captures risk (such as those obtained from surveys of beneficiaries or encounter data collected by plans and their contracting providers), further development of risk adjustment models, and implementation of adjusted payment rates.

EFFECTS OF CHANGE

The effect of any payment changes on total Medicare payments, plans, and beneficiaries will ultimately depend upon how they are implemented, how much payment levels change, and how plans and beneficiaries respond. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk plan payments will differ, depending upon the exact combination of policies and the sequence in which they are calculated.

The effects of changes on plan participation and beneficiary enrollment are also uncertain. If plans and beneficiaries are sensitive to payment rates, then rate changes could lead to participation increases in areas with increased rates and declines in those where rates drop. But if plans and beneficiaries are relatively insensitive to risk-plan payment rates, then we might not see such effects.

Unfortunately, there is little information that could guide us in predicting how plans and beneficiaries will react to payment changes. Researchers have been examining this question but their conclusions have been mixed. One recent analysis indicated that plan entry into the risk program is highly sensitive to the local payment rate. Another published study found that beneficiary enrollment rates are much more sensitive to factors such as local managed-care penetration in the commercial market than to local Medicare rates.

If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required in order to make accurate budget projections. In particular, it will be important to understand how beneficiaries of different risk categories select between managed care and fee for service. The Commission has concluded that any changes in payment policy should be designed and phased in so as to reduce disruptive effects on beneficiaries and plans.

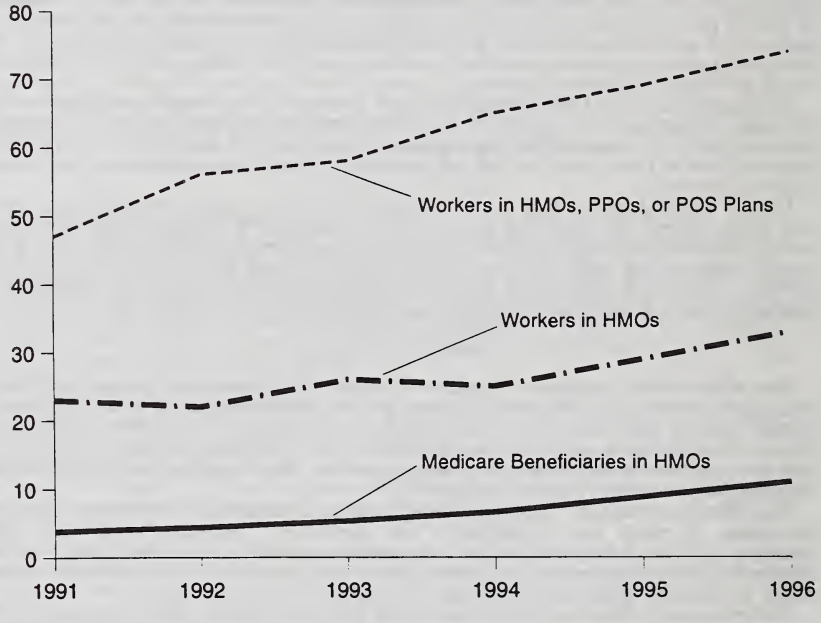
CONCLUSIONS

In its March 31st report, the Commission will make a series of recommendations concerning managed-care payment policy, many of which I have already mentioned (Figure 10). It is important to recognize, however, that payment policy is only one of the factors that will determine the future of managed care within Medicare and

its impact on the federal budget, beneficiaries, and providers. Realizing the potential of Medicare managed care will also require policy changes to minimize risk selection. Policies concerning information available about choices, the enrollment and disenrollment process, and enrollee grievance procedures must work together to allow plans to compete effectively and to protect beneficiaries. The Commission has made a variety of recommendations about these topics that I hope will provide the Congress some guidance.

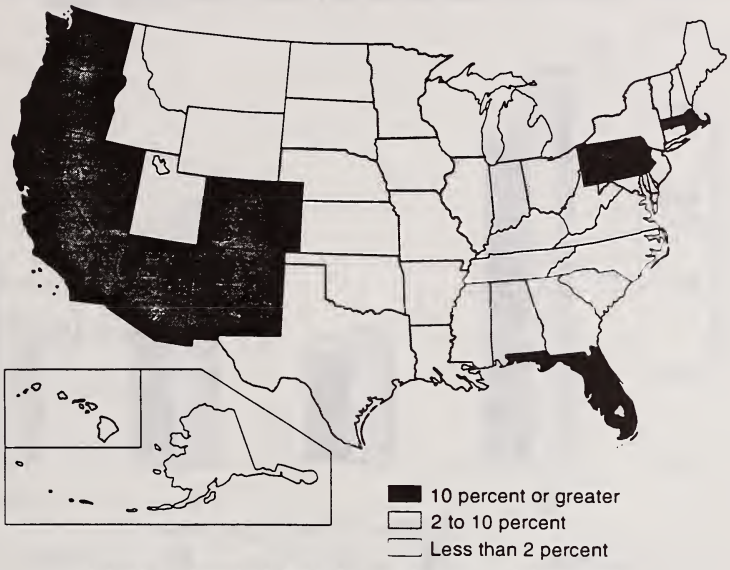
I would also like to take the opportunity to mention that since the vast majority of Medicare beneficiaries remain in fee-for-service (and are likely to do so for the next decade), the Commission has also devoted some time to issues related to improving traditional Medicare's performance. I would be glad to provide information about these issues to the Committee.

Figure 1. Trends in Managed-care Enrollment, 1991-1996



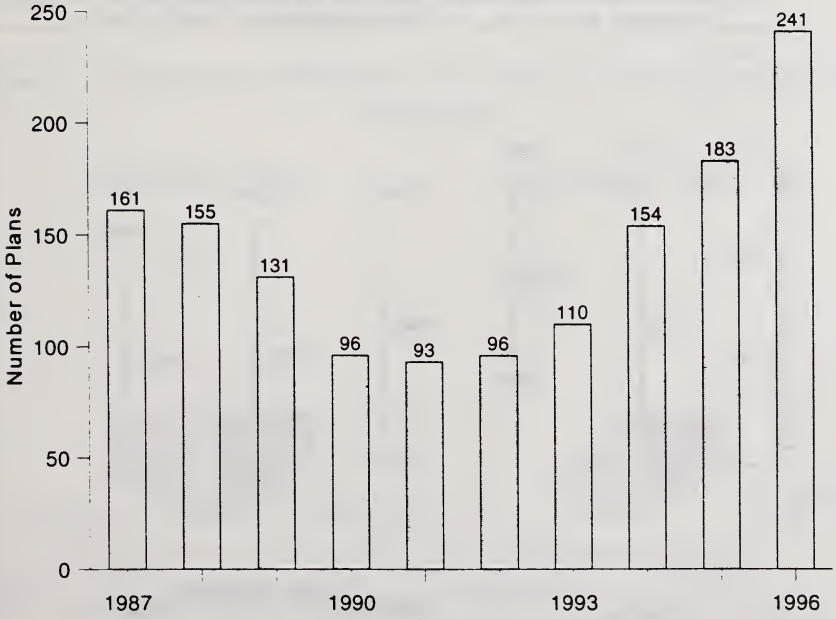
NOTE: Data for workers refers to workers in firms of 200 employees or more
SOURCE: PPRC analysis of data from HCFA and KPMG

Figure 2. Percent of Medicare Beneficiaries Enrolled in Risk Plans, by State, December 1996



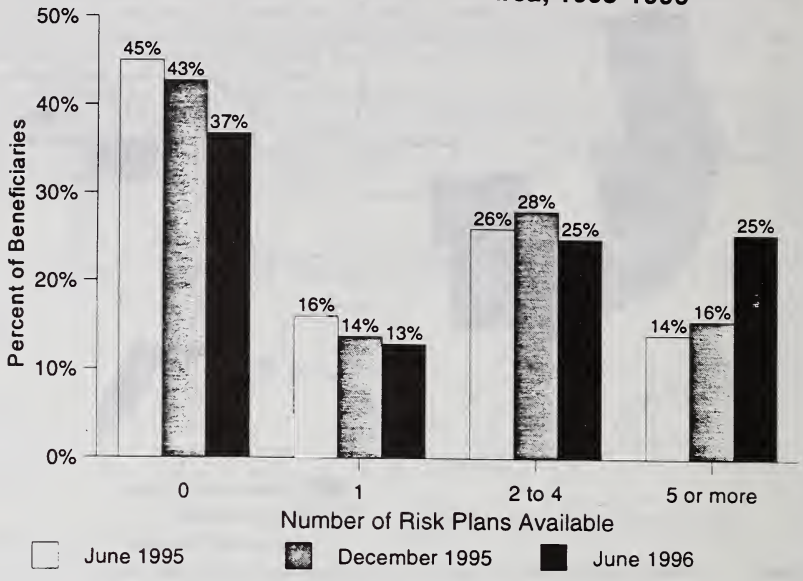
SOURCE: PPRC analysis of Medicare Managed Care Contract Report, December 1996.

Figure 3. Number of Risk Plans Participating in Medicare, 1987-1996



NOTE: All data are for December.
SOURCE: Health Care Financing Review, 1996 Statistical Supplement; Medicare Managed Care Contract Report, December 1996.

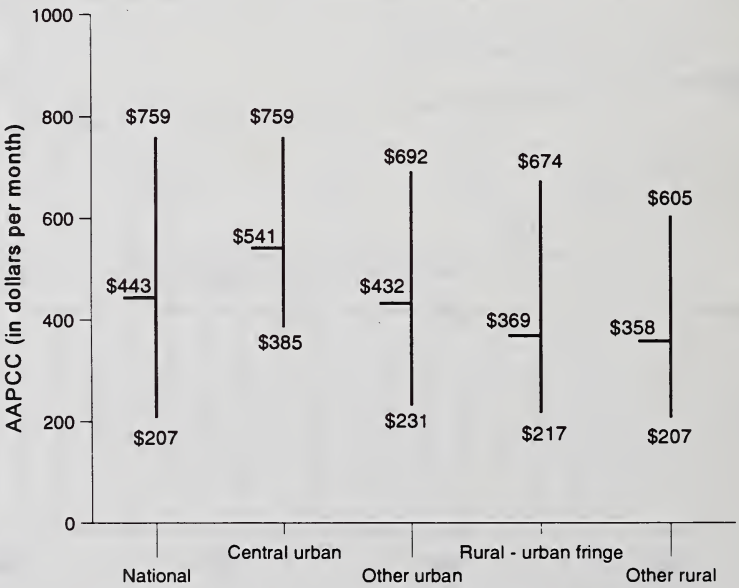
Figure 4. Distribution of Medicare Beneficiaries, by Number of Risk Plans Available in Their Area, 1995-1996



NOTE: Area is defined as the zip codes in a risk plan's service area.
SOURCE: PPRC analysis of HCFA data.

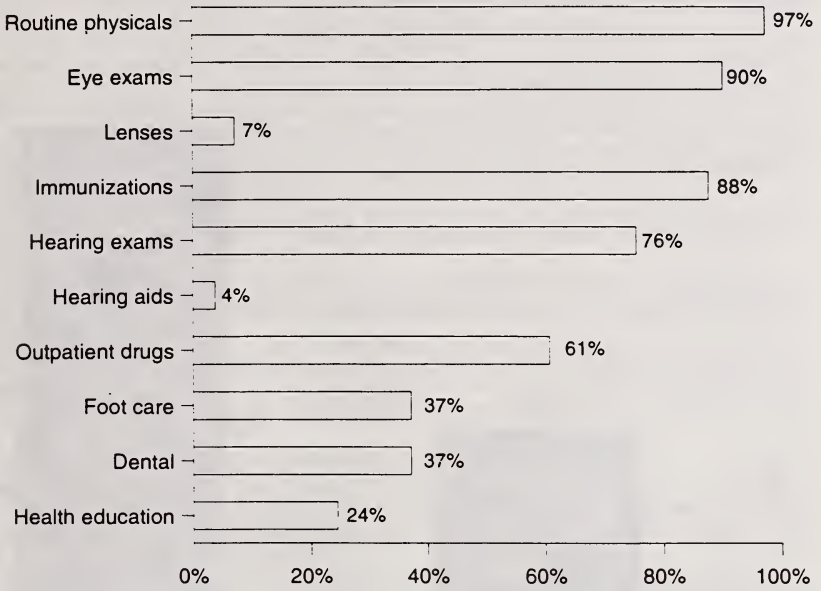
Figure 5. Spread of County AAPCCs by Location, 1996

Minimum, Maximum, and Mean weighted by beneficiaries



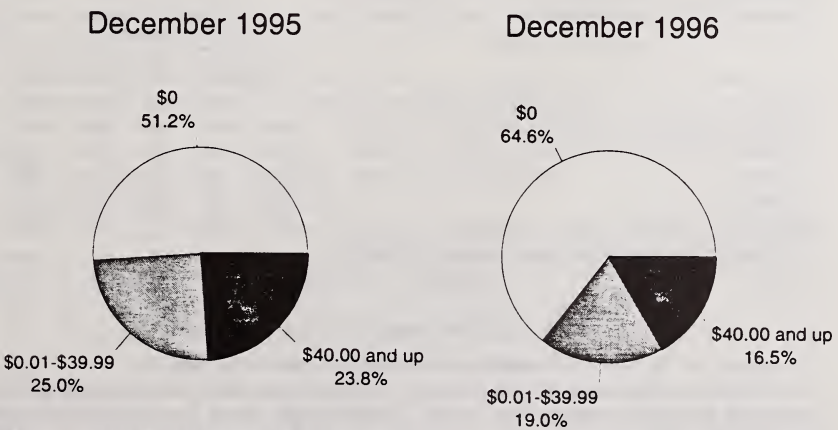
NOTE: Three AAPCCs are presented for each category: the lowest and highest AAPCC among the counties and the mean weighted by the number of beneficiaries per county. Loving County, Texas, was excluded because it had an extremely high AAPCC ($887) but a very small population. Its AAPCC dropped 40 percent for 1997.
SOURCE: PPRC analysis of HCFA data.

Figure 6. Percentage of Medicare Risk Plans Offering Additional Benefits in Their Basic Option Package, December 1996



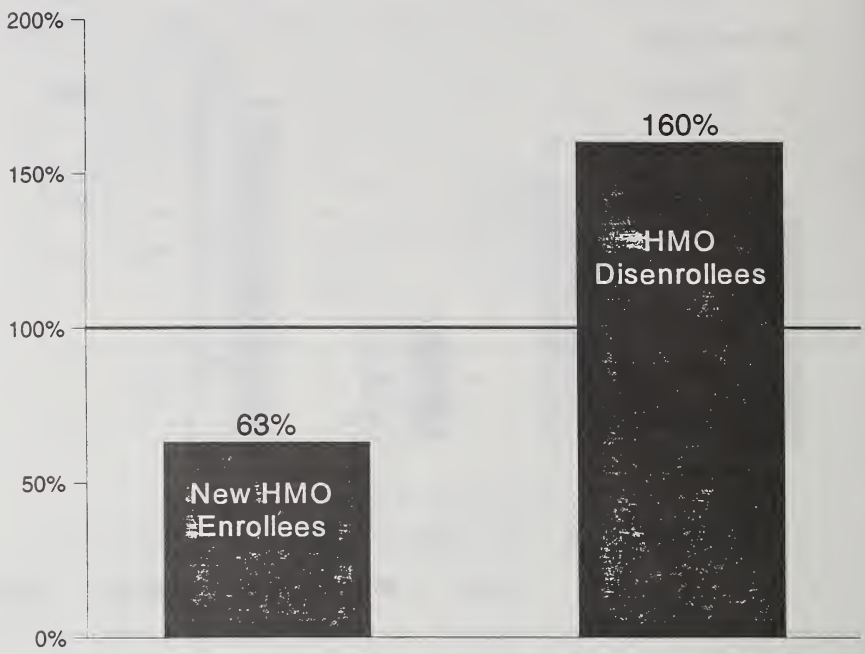
SOURCE: Medicare Managed Care Contract Report, December 1996.

Figure 7. Distribution of Medicare Risk Plans by Premiums Charged, 1995-1996



SOURCE: Medicare Managed Care Contract Reports.

Figure 8. Costs as Percentage of Average Medicare Spending per Beneficiary



SOURCE: PPRC analysis of 1989-1994 Medicare claims and denominator files, 5 percent sample of beneficiaries.

Figure 9. Length of HMO Enrollment for Medicare Enrollees in FiveLarge Risk Contracts, June 1994

Length of Enrollment In Years	Percent of All Enrollees					Total for Top 5
	Plan A	Plan B	Plan C	Plan D	Plan E	
Under 1	11%	22%	14%	7%	18%	15%
1-2 years	12%	23%	11%	6%	17%	14%
2-3 years	8%	13%	11%	5%	11%	10%
3-4 years	6%	8%	12%	5%	10%	8%
4-5 years	5%	6%	10%	6%	7%	7%
6 or more	59%	28%	41%	71%	38%	47%

SOURCE: PPRC Analysis of Medicate 5 Percent Enrollee Data Base (EDB) file.
NOTE: Age-ins are individuals who enrolled in the HMO in their first month of Medicate eligibility. Age-ins were placed in the "6 or more" category.

FIGURE 10. COMMISSION RECOMMENDATIONS

Revising the Method for Determining Medicare Capitation Payments

Several modifications should be made to make the AAPCC a more reliable estimate of expected patient care costs. These include using better risk adjustment methods, excluding payments to hospitals for graduate medical education expenses and disproportionate share of low-income patients, including the cost of care currently provided by other institutions, such as the Departments of Veterans' Affairs

and Defense, that is likely to be provided by managed-care plans, and basing the AAPCC on larger geographic areas.

Once graduate medical education costs are removed from the AAPCC, separate mechanisms should be developed to ensure that hospitals, managed care organizations, and other training entities are paid fairly for these costs when they are involved in appropriate training activities. Medicare payment policies should be developed to pay for graduate medical education in different settings.

The net effect of alternative policy combinations must be considered as they are developed and evaluated. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk-plan payments will differ, depending on the exact combination of policies used and the sequence in which they are calculated. Any changes in payment policy will affect the relationship between Medicare managed care and fee for service with regard to per capita outlays, benefits and premiums. Changes should be designed and phased in to reduce disruptive effects on beneficiaries and plans.

If the AAPCC is the base for setting rates that are unlinked from fee-for-service spending in the future, then it would be appropriate to make technical improvements to the AAPCC.

The Health Care Financing Administration should continue to test alternative methods for setting local payment rates, such as competitive bidding, partial capitation, and reinsurance.

Expansion of Medicare managed care raises issues beyond setting payments to plant. The Commission reiterates recommendations with regard to the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures that were described more fully in its Annual Report to Congress 1996.

Implementing Risk Adjustment In Medicare Program

Medicare should adopt a new system for risk-adjusting its payments to managed-care plans. As a first step, Medicare should immediately begin the phase-in of risk-adjusted rates by making modest payment changes using currently available Medicare administrative data and methods.

Over the longer term, the data and infrastructure required to support risk-adjusting payments based on the best available methods should be defined, developed, and implemented.

Medicare should adopt data reporting requirements consistent with the needs of the new risk adjustment system. This should include information on individual beneficiaries diagnoses.

During the phase-in of risk adjustment, changes in plan payment rates should be limited to protect plans and the beneficiaries they serve from sharp swings in payment.

Medicare should immediately enforce the existing requirement that hospitals report "no-pay" bills for hospitalized Medicare managed-care enrollees.

Medicare should establish an orderly phase-in for all components of the risk adjustment system, including data reporting, further development of risk adjustment models, and implementation of adjusted payment rates.

Mr. BILIRAKIS. I thank you, sir.

Let me start this off by asking a basic question.

Did HCFA or the administration request inputs from your three groups before they came up with their plan in the budget?

Mr. YOUNG. As for ProPAC, no, they did not.

Mr. BILIRAKIS. Dr. Taylor?

Mr. TAYLOR. There's been a lot of data exchanged back and forth between the commission and HCFA but I can't comment on the specific question. I don't know the answer.

Mr. BILIRAKIS. You don't know the answer. Dr. Ratner?

Mr. RATNER. We talked with the HCFA research staff but we didn't have any discussions about their proposal.

Mr. BILIRAKIS. All right. Now these recommendations that Dr. Taylor finished up with, the Commission recommendations, on your Figure 10. Were those recommendations passed on to HCFA? As far as you know, were they considered at all?

Mr. THOMPSON. These recommendations were finalized at the last commission hearing just a week ago, and our report goes to Congress on March 31, so I think the answer is no.

Mr. BILIRAKIS. The answer is no. Well, all right. You were I guess in the audience when I raised the question about what the effect of reducing these payments to the HMOs might have on the expected increases.

I mean would they result in a slowdown in fact—would the proposed cuts in the AAPCC result in a slowdown in enrollment of Medicare, HMOs, and Mr. Fried testified to the contrary.

What is your general opinion regarding that?

Mr. TAYLOR. The commission really hasn't studied that particular question. I think the long-term impact of slowing the rate of growth lower than the rate of general inflation or the rate of medical inflation would suggest at some point there will have to be a squeeze somewhere. You would think that the squeeze would potentially be in the optional benefits and/or the availability of zero premium plans, but really the commission has not analyzed that.

I am just giving you my personal opinion.

Mr. BILIRAKIS. So if what you say would take place then we'd probably be talking about a slowdown rather than an increase of the number of Medicare HMOs, is that right?

Mr. TAYLOR. I wouldn't be able to project that because again, as Bruce Fried said, it's a very competitive environment out there and we are seeing a rapid increase in the number of plans. I am sure that it is all relative to how much Medigap costs and the benefits, or perceptions of benefits of fee-for-service Medicare as a competitor.

Mr. BILIRAKIS. Dr. Young.

Mr. YOUNG. The commission also does not have a position specifically on the question you asked. CBO, as you heard, has projected that the net effect would not either accelerate or decelerate the growth.

The commission does have some information however that is potentially relevant to it. If you look at reasons the plans might well participate, and we did an analysis of it last year, Medicare's rates are an important factor, but there are multiple other factors plans to look at besides Medicare's rates and the determination of whether to participate in a large area and the rates play a much smaller role once they are in a large area in the decision whether to participate at the county level.

If you look at it from the point of view of the beneficiary, my Chart 2 laid out wide swings in extra benefits, and clearly many Medicare beneficiaries are choosing managed care plans when the extra value of benefits is quite small.

It is likely that to an extent at least the administration's proposals, and they fit in concept with the ideas the commission has laid forward—there are some technical details that differ—it would compress the high end of those extra values and perhaps elevate the low end of those, leading to the net tradeoff in terms of values.

Likewise, we also know from our work that within any metropolitan area with a number of plans there's quite wide-ranging differences in the extra values that are offered that probably reflect differences in plan performance, differences in enrollees, so the sys-

tem is still very fungible in terms of how titrating rates will affect enrollment and CBO's projections are probably as reasonable as any.

Mr. BILIRAKIS. Dr. Ratner.

Mr. RATNER. The first thing is that a complex package like the administration proposal is going to have lots of different effects. Sorting out the net effect is hard and the CBO has said that it thinks on average probably those effects might be a wash.

Looking at the payment rate, I agree with Dr. Young that there probably would be some effect on enrollment. But we have to remember that this is a program that has a huge momentum of 30 percent enrollment growth and that there are many areas in which the general HMO presence in the area is driving the participation in the Medicare market. The payment rate may not be as decisive as some people might think.

Mr. BILIRAKIS. I see. Interesting. Thank you.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Dr. Young and also Dr. Taylor, I guess you formerly worked at PacifiCare Health System, if you would answer this question too.

ProPAC supports the administration's policy to remove special payments associated with teaching and disproportionate share from managed care payments.

The managed care industry says that removing these payments may force these plans to take the extra services away from beneficiaries.

Do you believe that will happen?

Mr. YOUNG. That is related to the question that I addressed earlier. To the extent that the rates are reduced, plans will have to make a decision as to how they operate, how they market, and what they offer.

Today under the rates there is wide variability in what they offer, and as I pointed to Chart 2, it may well be that those 10 percent of people who are getting $112 a month in extra benefits might get less than $112, but it is also true that those that are getting less than a dollar in benefits would get a higher amount.

Second, the commission's view is that the Congress has legislated those adjustments and spent the Medicare dollars for the purpose of achieving access for Medicare's beneficiaries to those important hospitals and that those moneys should go directly to those hospitals.

Third, it levels the playing field in that the plans can now negotiate with a teaching hospital and a non-teaching hospital on the rates they wish to pay without the factor of Medicare's extra payments coming into play. The hospital will get those. The hospital knows it and the plan knows it, so the bottom line that the commission believes is that it is good public policy to remove those dollars. They don't belong in that level and it probably will not have a substantial overall adverse effect because the dollars didn't belong there to begin with.

Mr. BROWN. Dr. Taylor.

Mr. TAYLOR. I think if you look purely at the issue of removing GME and DSH and then you look at someplace like the Bronx with 25 percent of the capitation payment being GME and DSH. Clearly

if you remove 25 percent you would have a significant downward pressure on the benefits that could be offered and the plan's interest and growth. But the hold harmless provision in the administration's proposal certainly blunts the impact significantly in those kinds of markets.

I think the position of the commission was that GME and DSH were to be used for different purposes than how the AAPCC was currently being used. Therefore these should be removed. But the commission has also been on record as saying that the GME funding mechanism should also be significantly revamped and it did go on with its recommendation to say that there should be a mechanism to get those funds back in where they belong including supporting those managed care organizations that are doing appropriate training.

In terms of my personal position as the Commissioner and a former executive at a Medicare risk plan, I expressed my opinions along with other Commissioners and we came up with our common belief. But I think that there is significant concern that there is a need for both reform on the GME side and on the AAPCC side and that there needs to be some linkage.

Mr. BROWN. One last question, Mr. Chairman.

Dr. Young, you said earlier, "Even the best available risk adjustment method will not fully offset efforts by plans to seek out healthier beneficiaries."

The partial capitation method would pay plans partially on the basis of their enrollees' utilization rates, how would that system work?

Mr. YOUNG. The system envisions using fee-for-service spending and fee-for-service utilization together with capitation, so that there is a limit that—the plan's risk is limited by the fact that individuals who would be sicker and receiving more services would also receive additional payments through the fee-for-service side of the mechanism.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Mr. Whitfield.

Mr. WHITFIELD. Thank you. Dr. Taylor, the adjusted community rate, which I assume every managed care organization is required to calculate, how do you all calculate that?

Mr. TAYLOR. I am no longer in a Medicare risk contracting HMO, but the ACR has a specific formula that is designed by HCFA and all the plans are required to submit under a standard methodology.

It is essentially designed to make sure that the standard sort of benefits, standard sort of margins and the standard sort of administrative costs that you are able to sell on the commercial market adjusted for a Medicare population are in place for the Medicare population.

It is essentially a protection against the plans making an inappropriate level of margin, for example on Medicare——

Mr. WHITFIELD. But it includes the margin of profit?

Mr. TAYLOR. It includes the profit that is in, was in the administrative retention of the plan for its commercial business. I guess essentially the policy assumes that whatever the market has borne on the commercial side is not inappropriate to bear on the Medi-

care side, but it provides a level of protection that it not be inappropriately high on the Medicare side.

Mr. WHITFIELD. So is there an average profit margin that we could say would be there in a normal calculation or not?

Mr. TAYLOR. Do you know that?

Mr. YOUNG. I need to add one additional point. It is a fairly complex kind of a calculation but it is based on the experience that is in the private plan for their costs of providing care.

To the extent that the Medicare's costs are three to four times higher, if they—let's say they had a profit margin of 5 percent multiplied times a thousand dollar premium, Medicare would pay them 5 percent multiplied times a $4000 premium.

They would get four times as much profit because of the way that that calculation is set up.

On the other side of the coin, their administrative costs may be very low because they are dealing with large employers. They don't have individual marketing expenses. They will get paid based on Medicare's amount, which the dollar amount would be multiplied by four under my example, but their costs could be substantially higher.

So that formula and that approach for deriving extra benefits is one that has outlived its usefulness and the commission has a recommendation also to move to a better way of calculating those benefits.

Mr. WHITFIELD. So from your perspective, the adjusted community rate is out of date and——

Mr. YOUNG. It's an out-of-date methodology and it's based on commercial experience applied to Medicare which is not appropriate in many respects and it would be easy enough for plans to submit information after they have been in business in the aggregate—we are not talking about detailed cost reports—that would tell the program about their experience directly with Medicare program and we think we could get a better set of information doing that.

As far as profits, and the question you asked directly, we do not have that information. There is a category that includes profits and administrative costs but you can't sort the two out, which is profit and which is administrative.

Mr. WHITFIELD. But anything above the community rate, the difference in that and the AAPCC payment has to either go back to Medicare or in benefits to the beneficiary?

Mr. YOUNG. Yes, sir, that's correct.

Mr. WHITFIELD. Okay. Now is the community rate calculation, is that required by statute or is that by regulation?

Mr. YOUNG. I believe there is a statutory requirement.

Mr. WHITFIELD. Okay—we think, okay.

Mr. YOUNG. We are not certain about that, sir.

Mr. WHITFIELD. Okay. I'm not, for sure, but—we'll try and find out.

Second of all, I do want to pursue just for a moment this test case over in Baltimore on competitive bidding or opening up to the market system, and I think one of your groups was involved in that, and why was it they were not able to conduct that test and has HCFA conducted other tests related to the competitive bidding?

Mr. YOUNG. I do not have direct knowledge of that.

I have talked to a number of people about it but I do not have direct knowledge.

My understanding is that there were several factors.

One, the State of Maryland is somewhat different than the rest of the United States anyway in terms of its Hospital Cost Containment Commission.

Second, Maryland, was preparing to undergo a number of other demonstrations in regard to Government funding and they didn't want the extra burden, and the third was that the plans felt that they had not been consulted and did not understand or did not wish to participate in the program and that it would not be appropriate, so that all of those together led to a mountain of opposition.

Mr. WHITFIELD. Yes?

Mr. TAYLOR. If I can just add, one of the policy issues that came up there and will continue to come up whenever we unlink fee-for-service Medicare experience from what we pay health plans is the fact that you could be in a situation where you would be paying considerably more in the fee-for-service environment. The health plans competing on a much-reduced premium through competitive bidding could in fact be in a much constricted environment. So essentially you could set up a difficult situation where you are asking people to reduce their choice to come into managed care since they would get just bare bones benefits because of the premium of contribution differences. This brings up the broader question of whether a demonstration shouldn't also somehow be checking the ability to do a defined contribution or somehow a pseudo-premium on the Medicare fee-for-service side so you don't get that mix.

Mr. WHITFIELD. But we would be able to work with you on a formula other than this community rating formula? I mean you would be able to facilitate that and provide information on that?

Mr. TAYLOR. PPRC has been very supportive of HCFA moving forward with demonstration projects and has made a number of recommendations to avoid some of the difficulties in the early projects and we would be very happy to work with you.

Mr. WHITFIELD. Thank you.

Mr. GANSKE [presiding]. Gentlemen, I want to thank you for being here today. It's my turn now.

I think that, Dr. Taylor, your charts are very well done. In fact, I may use them in some things.

As I look at the map of the United States, my eyes of course are drawn to the center, where Iowa is, which is white, which is basically "there are none" or very few enrolled in Medicare HMOs. And then if you look at the dark areas, such as New York City, Pennsylvania, Dade County, California, HMO enrollment is much higher. And if you then go to Figure 6, when you look at what additional types of services are able to be offered for the HMOs in those areas, it is easy to see why, when you look at what the AAPCC is in those areas, how we can have a tremendous disparity in the types of services that are available to people across the United States.

If you are so fortunate as to live in Miami, you get free prescription drugs, et cetera.

I see this whole issue as really having two components, and you and Mr. Fried have agreed that there's something wrong with the way the AAPCC is calculated, and I agree with that.

The subsets are, I think, savings and fairness.

When we addressed this issue 2 years ago we did it in a more or less budget neutral fashion. In other words, we set up a much simpler way of achieving more national uniformity by allowing those at the top to grow at 4 percent, those at the bottom at 8 percent and then some variation in between.

We did that for a reason. The reason was we didn't want to get into a food fight with the States.

I want to just ask you, are any of you concerned that with the way the administration has set this up, especially with the year 2000 when there's a steep cut, that we are going to see such an outcry because you will see payment reductions in some areas, about whether this is the best way to go.

Maybe we could start with Dr. Ratner.

Mr. RATNER. Yes, sir. We are concerned about that aspect of the proposal, partly because it is a notch the way you have described, but also because of the question of what the basic principles are that you want to run the payment system on. I think the ones of having accuracy, efficiency, a level playing field for health plan options and fairness are widely accepted ones. I think if you look then at practical things to do, the two things that jump out are what we at GAO talked about: first, try to correct the accuracy of this county AAPCC and, second, as we have testified 2 years ago before this committee, introduce an interim risk adjustment that would start nibbling away at some of the excess payments and level the playing field between plans as well.

I think if you did that some of the concerns that you have might not come into play.

Mr. GANSKE. Dr. Young.

Mr. YOUNG. Yes, the same kinds of concerns.

One is the cliff. If one were to do something, then one would like to have a longer transition, just as we have had with other programs, but the more fundamental concern is that it's an across-the-board cut that takes dollar amounts that we agree with in terms of the need to adjust for risk, but it applies them willy nilly and it doesn't distinguish among the risks the plans have.

You or somebody else pointed out in the questioning that in fact a county that doesn't have any enrollees is losing it as well.

You need to adjust based on risk. This if anything will have the savings initially but will exacerbate the problem substantially. It will increase the incentives for plans to select, not decrease the incentives for plans to select.

Now my understanding from conversations with individuals in the administration is that they hoped to have a risk adjuster to implement by this time, but that is a promissory note that is in place and you need to risk adjust at the individual level to be fair to plans and to the individuals in the distribution of those payments. An across the board court cut does not do that and in fact could exacerbate things.

Mr. GANSKE. Dr. Taylor, I want to ask a different question, I think, because our time is limited.

On Figure 8 you point out that new HMO enrollees are costing as a percentage of average Medicare spending per beneficiary 63 percent, HMO disenrollees, 160 percent.

Mr. Fried said, well, over a period of time, you know, when you get bigger pools that may even out and after all only 3 percent, disenroll and go back to the fee-for-service. I would point out that it's about 5 percent of the Medicare population that accounts for about 50 percent of the program's cost.

I want to ask you specifically, are you concerned that the administration's plan to require community rating of Medigap plans would actually allow seniors to leaved managed care plans more easily and therefore exacerbate the problem of adverse selection that you have pointed out in your graph? Dr. Taylor?

Mr. TAYLOR. My sense, if anything, is that by having eliminating of preexisting conditions and community rating, you will get more freeflow back and forth so seniors won't feel either constricted to stay in the plan, nor will they fear going into the plan. So, if anything, it might have a tendency to more neutralize that risk factor. The HMOs themselves cannot have preexisting exclusions so I don't necessarily see that having an impact in that regard.

Mr. GANSKE. Well, we have seen in some States that have done community rating situations where if a patient gets sick in a managed care plan and then can switch back into a traditional plan easily, that you cannot allow for a true expensing of what that patient's cost will be, that you run into some significant problems. And, you may end up then with such a high cost in that secondarily selected pool that you are actually setting up a spiral.

Dr. Ratner, would you care to comment on that? Do you have an opinion on this? The administration wants to do community rating and then allow Medicare managed care patients to switch back in and not allow insurers to take into account the fact that, at least according to the PPRC's data, this is a sicker bunch that is transferring back into Medigap.

Mr. RATNER. This is one of those situations where we don't have the evidence, really, to know which of the two things is stronger: whether the effect that you are talking about is stronger or whether the effect of people who have been scared to go into an HMO—to put their toe in the water because they are afraid of not being able to get the Medigap—whether that effect is stronger, and they would now be encouraged to join an HMO.

It is hard to know and I don't think we have the evidence. At least I don't.

Mr. GANSKE. Should we put in some safeguards in this area? Karen Davis of the Commonwealth Fund has suggested that we could impose penalties on high disenrollment rates to combat selection problems.

Dr. Young?

Mr. YOUNG. I think the larger problem that we are dealing with here is not the Medigap and the community rating but Medicare's current enrollment and disenrollment policies and I put those into two categories.

First are the policies regarding individuals who have not been in managed care previously and/or new to the Medicare program and there I think it is reasonable to give them an opportunity to try

it out and to encourage it and if they decide they don't like it to either go to a second plan or to go back to fee for service.

On the other hand, for those that have been in managed care for some time, it doesn't make a lot of sense to allow them to disenroll every month, every 30 days. It encourages the kinds of behavior that you are talking about. Another option that was considered last year in your consideration of the balanced budget act was to change Medicare's enrollment and disenrollment policies, realizing you have to give the new ones some opportunity to test it out and try it out but allowing them to disenroll every 30 days may not be good public policy and if they make a commitment to join a plan and stay with it, that commitment should be exercised throughout a year or through some period of time which is longer than 1 month. I think that is the more fundamental problem.

Mr. GANSKE. I happen to be a strong supporter of medical savings accounts and I regret that I didn't get a chance to talk to Mr. Fried about this. Opponents of MSAs basically cite the adverse election issue which you have so nicely pointed out occurs currently in Medicare managed care. But it seems to me that this is not something that is necessarily related to the type of insurance that is offered. I think it can occur in any type of coverage and there are reasons why it would.

Do you think that it is possible across the board for whatever choices we come up with for Medicare, whether it is managed care or some additional choice such as MSAs, by nature of changes in lengths of time that recipients have to stay in a plan once they are in; i.e., how often they can disenroll, to take care of a potential adverse selection process?

Dr. Taylor?

Mr. TAYLOR. I think there is a fundamental need for risk selection methodology even if you had 100 percent of the community in Medicare risk, because you really have the issue of selection between risk plans as well. And, you know, some provider-sponsored network that is going to have a great cancer center might attract some more cancer patients, very logical, very appropriate. And it should have risk adjustment.

If you start having a broad range of Medicare choices, you start segregating risk and then it even becomes more important to have risk selection methodology and modifications through the AAPCC or the payment method, just because of the problems of segregated risk.

When you add MSAs or, in fact, any range of benefit structures that are significantly different from each other, you also get risk selection between types of benefit plans and especially with the possibility of a refund of part of your premium. So I think all that really begs, even more so, for risk selection methodology.

Mr. YOUNG. I absolutely agree. Assuming plans are not redlining, assuming they are not engaging in behavior that would generally be viewed as antisocial behavior, there is nothing inherently wrong with risk selection. What is inherently wrong is the failure to adjust the payment to meet the probable and expected risk that you have and Mr. Taylor gave a couple very good examples of where that would happen.

Mr. GANSKE. Any final comment, Dr. Ratner?

Mr. RATNER. I would just add that this is an area where you don't want to put all your eggs in one basket. I think that considering some administrative rules about length of time is one way to go, to deal with some of the risk selection possibilities. But the other thing, as Dr. Taylor has emphasized, is that having some method of trying to take account of those differences in the healthiness of people is also very important. None of these things is perfect and trying several of them probably, and revising them, is probably going to be the necessary way to go.

Mr. GANSKE. I want to thank the panel very much and, with the chairman's indulgence, thank you.

[Whereupon, at 4:03 p.m., the subcommittee was concluded.]

[Aditional material submitted for the record follows.]

QUESTIONS SUBMITTED BY HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Under current Medicare authority, there is a requirement called the "50/50" rule, which requires that managed care plans have no more than 50 percent Medicare and Medicaid beneficiaries and that the other 50 percent must be commercial enrollees. As we both know, this provision is one of many protections Congress enacted to ensure quality for Medicare beneficiaries. However, as we begin to explore this area, we find there may be some plans, such as those operating in inner city areas where there are more low-income beneficiaries who are on Medicare and Medicaid, that may not be able to attract the 50 percent commercial enrollment. In those specific types of instances, do you think the Administration should have authority to grant waivers of the 50/50 rule?

2. If the Administration's proposal were enacted, would the Secretary have adequate authority to grant waivers of the 50/50 rule for meritorious plans? And if these plans performed adequately, would the Administration's proposal provide sufficient authority to allow these plans to continue once their waiver has expired?

3. Based on what you know about the Detroit, Michigan Wellness Plan, which has a longstanding quality track record, primarily serving the Medicaid population, would this plan be the type of plan that would be eligible for a waiver of the 50/50 rule on enactment of the proposed legislation?

DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
April 22, 1997

The Honorable JOHN D. DINGELL
2328 Rayburn House Office Building
Washington, D.C. 20510

DEAR MR. DINGELL: Subsequent to my appearance before the Commerce Committee, you submitted several questions to our office regarding the 50/50 rule. As you know, the 50/50 rule requires that a Medicare HMO's Medicare and Medicaid enrollment not exceed 50 percent of its total enrollment. Under current law, the Secretary already has the authority to waive the 50/50 rule for plans in areas with high proportions of Medicare beneficiaries and for government operated plans for a three year period.

Under the Administration's FY 98 budget, the 50/50 rule would be repealed once a new quality measurement system was in place. In the interim, the Secretary would have additional authority to waive the 50/50 rule (1) for managed care plans serving rural areas, (2) for plans with good track records as a plan contracting under Section 1876 of the Social Security Act and (3) in any other circumstances the Secretary deems is in the best interest of beneficiaries. Once a plan's waiver has expired, the Secretary could reassess whether the waiver should be renewed. If the Administration's proposal was enacted, the Secretary could consider granting the Wellness Plan a waiver of the 50/50 rule if she believes doing so is in the best interest of beneficiaries. The two other waiver authorities would not apply to the Wellness Plan since the plan does not serve a rural area and does not have any "track record" as a plan contracting under Section 1876. I would also like to note that the Administration's budget proposal would modify the 50/50 rule by excluding Medicaid enrollees from the calculation, thus an HMO's Medicare enrollment only (not Medicare and Medicaid) could not exceed its commercial enrollment.

I trust that these responses adequately address your questions. Please do not hesitate to call me if you have further questions or concerns.

Sincerely,

BRUCE MERLIN FRIED
Director, Office of Managed Care

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